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The Salvation Army World Service (SAWSO)

Community Health Project

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Forward

On the second to the last day of this evaluation I met with 12 representatives of the Council of Headmen who advise the Salvation Army health program in Zambia. These old men complained to me in unequivocal terms about how life had changed in their communities. As if years of death, drought and animal disease were not enough, the Salvation Army was closing hospital wards and opening rural clinics, increasing fees and introducing insurance schemes. Underneath their not-so-subtle pleas for more assistance (they assumed I was a donor) was also a power and assurity—they know the future is in their hands. This power comes in part from the partnership the Salvation Army is building with their communities. At the end of the session, after repeating again that I could grant no wishes and make no promises, they asked, simply, that I bring their message back to my people. This I could promise. I hope this report lives in some small way up to their expectations.

Whatever critical comments are presented in this document are conveyed with constructive intent. I carry away from every project I visited the utmost respect for the commitment and dedication of the people who are making them real on the ground, often against significant odds. Much of what appears here has already been shared with Salvation Army staff in Bangladesh, Indonesia, Zambia and the U.S. Their willingness to acknowledge both the strengths and weaknesses of their programs and to consider recommendations in the spirit of building a better program, without overly personalizing the feedback, is laudable.

Thanks to Faye Hannah and Bram Bailey of SAWSO for their honesty, good nature and companionship, as well as their input into this report. Thanks to Rosemary Regis and Stacey Lissit of SAWSO for their insights, to Peggy Meites and Joy Pentecostes of USAID for their guidance, and to AMATech for inviting me to undertake this evaluation. Thanks to my son for minding the house and the cat, and to both my kids and Mark for not minding too much that I was away.

Laurie Zivetz
Washington D.C.
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ACRONYMS

AN	Antenatal
ARI	Acute Respiratory Infection
BHR	Bureau for Humanitarian Response
CPT	Care and Prevention Teams (Zambia)
CSG	Community Support Group (Bangladesh)
DIP	Detailed Implementation Plan
FPW	Family Planning Worker
IHQ	International Headquarters (of the Salvation Army)
JSI	John Snow, International
KPC	Knowledge, Practice and Coverage
MCH	Maternal-Child Health
MG	Matching Grant
MIS	Management Information System
NGO	Non-governmental Organization
ORS	Oral Rehydration Solution
PLA	Participatory Learning Appraisal
PRA	Participatory Rural Appraisal
PVC	Private and Voluntary Cooperation (Office of)
SA	Salvation Army
SAWSO	Salvation Army World Service Office
TBA	Traditional Birth Attendant
THQ	Territorial Headquarters (of the Salvation Army)
USAID	United States Agency for International Development
VHW	Village Health Worker

EXECUTIVE SUMMARY

This report looks retrospectively at impacts, outcomes and issues arising from the implementation of the United States Agency for International Development, Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation, (USAID/BHR/PVC) Matching Grant FAO-A-OO97-00049-00 in Indonesia, Bangladesh and Zambia (Ghana was included in the Matching Grant but not the evaluation) for the period 1997-2000. All four countries were also covered by the pervious Matching Grant in the 1994-96 period. Ghana and Zambia has received another 3 years of support under this scheme.

The evaluator was accompanied by Salvation Army World Service Office (SAWSO) staff and spent 5 days in each site. In-depth interviews and focus groups were conducted with project staff, community health workers, village committees, groups of mothers, and government officials. Debriefing sessions were held with project staff on the last day of the review in each country. Debriefing notes, included in Appendix B of this report, constitute an integral output of this evaluation.

The Salvation Army has a long history in all of the countries covered, where it has been delivering curative hospital and clinic based services for decades. The addition of community outreach services--and the institutional adjustments this has entailed—began before the Matching Grant, and typically followed models being implemented by local governments. The Matching Grant served to underwrite the deepening and expansion of community outreach, including the training and support of volunteer cadres in all countries, and the establishment of community-based health and development committees in Bangladesh and Zambia. It also provided support for programmatic and structural integration, as well as, in some cases, staff training, Management Information Systems (MIS) development (including Knowledge, Practice and Coverage (KPC) surveys in 1995 and 2000) and, in Zambia, the development of a health insurance scheme.

The goal of the Matching Grant was: *to improve the health status of women and children in targeted communities in Bangladesh, Indonesia, Ghana and Zambia*.

The purpose is *to increase the capacity of local non-governmental organizations (NGOs) in those countries to develop, implement, monitor and evaluate sustainable community-based health programs.*

The program aims are stated as *to increase effectiveness and sustainability of local primary health care programs through: decentralizing existing Salvation Army community health services, promoting community ownership and involvement; designing systems for monitoring and evaluation that will be useful at all levels; and instituting fee for service and other strategies.*

Health impacts were generally high relative to targets (which in some cases were overly ambitious, especially in the Asian countries). Observation and discussions with villagers and health workers indicate enormous changes in awareness and positive health seeking behaviors over the last decade in all participating communities. Less impressive results relate primarily to instances where government assumed responsibility for certain interventions (immunization, for instance). Vitamin A capsule campaigns, introduced by governments in all three countries, eclipsed behavior change nutrition campaigns planned by the project, except in Bangladesh where it remained more or less the same. Impacts on health status can be linked to the community volunteer/community worker program, and the extent to which this cadre was well trained, motivated and supervised. Outcomes for Zambia are particularly impressive, given downturns in the economic situation and the impact of the AIDS epidemic in the target communities.

Despite its emphasis on sustainability in this three-year cycle, the program lacked an integrated plan for sustainability and capacity building. Each country program made progress on each of these dimensions. All countries took steps to reduce costs and raise fees for services, and to engage with communities to foster local ownership. Nonetheless, efforts to address sustainability were by and large random, and remain uninformed by a broader Salvation Army or SAWSO framework, a coherent plan, targeted technical assistance, or reference to the literature. SAWSO's vertical approach to program support and implementation precluded potential sharing and synergies across countries.

Lessons learned and innovations at the country level in MIS development, volunteer training and support, and insurance schemes remain undocumented, though some interesting outcomes appear to merit further investigation. Zambia has made progress in the design of an MIS system, which integrates hospital, clinic and outreach components and provides decision makers at all levels with usable information.

Although not an explicit objective of the Matching Grant, gender was not addressed in the design or implementation of the program or country projects. More needs to be done to redress the staff profile, volunteer and supervisor recruitment and design limitations which may be inhibiting optimal achievement of health program objectives based on lack of attention to gender.

Organizational issues internal to the Salvation Army's structure have given rise to some important findings related to the locus and nature of decision-making, links between traditional hospital structures and community outreach, and the relationship between the Army's evangelical and development missions in operational terms. The relative autonomy, which country or multi-country Territorial Headquarters (THQ's) enjoy in determining policy and projects, means that innovation and change is uneven in the organization. Mechanisms for sharing information and learning between THQ's (and at times between projects and THQ's, when they are geographically distant) are similarly undeveloped. The absence of a performance appraisal system at international or local

levels, coupled by the reality that development professionals—who are for the most part not members of the Salvation Army —report to Salvation Army Officers who have a variety of backgrounds and responsibilities--limits the extent to which professionals work within a clearly defined performance or promotion system. SAWSO has taken a relatively lower profile role in assertively promoting change, at least at the country level, than perhaps they perceive themselves to have, or what might be arguably optimal.

The next Matching Grant cycle presents SAWSO with an opportunity to apply lessons learned to the development of a strategic, holistic framework for sustainability and capacity building, and to encourage greater inter-country sharing. Key overall and country specific recommendations are outlined below.

SAWSO/General

There is a need for:

- An overarching and action-oriented strategic plan;
- Greater documentation and dissemination;
- Technical assistance to Country Offices;
- Tool development, for instance for MIS, training, sustainability, community volunteer programs;
- Greater advocacy for Community Health Volunteer programs within the Salvation Army system;
- Gender analysis and integration in programs;
- Greater dialogue among participating countries;
- Development of performance appraisal systems within the Salvation Army structure at international and country levels.

Bangladesh

- Seek resolution on the management structure of the project;
- Advocate for the program within the Salvation Army system;
- Develop a long term sustainability plan;
- Maximize local revenue generation to avoid donor dependency;
- Consolidate integration efforts;
- Increase attention to gender in terms of staff hiring and program design;
- Use existing clinic and project data more effectively;
- Undertake the proposed study of the doorstep family planning program;
- Undertake a study on the cost effectiveness of village health workers;
- Train village health workers to manage data more effectively.

Indonesia

- Revisit and realign current anomalies in institutional relationships in Palu;
- Develop a list of technical assistance requirements with SAWSO;

- Address the issue of recurrent costs for medicines by drawing on lessons learned from the posyandu insurance scheme system;
- Educate the THQ on community health programming;
- Share learning's with government; explore greater financial support.

Zambia

- Finish development of the MIS system and share it with other countries;
- Document the insurance scheme to be able to understand and share learning's;
- Revisit the number of types of staff and counterpart volunteers to see whether positions can be consolidated to enhance efficiencies;
- Mandate greater gender balance in CPT's;
- Continue support to CPT's;
- Do not encourage CPTs to take loans or operate as microenterprises;
- Revisit the gender issue when identifying community health volunteers;
- Model gender equity in hiring.

1. INTRODUCTION

This report looks retrospectively at the USAID/BHR/PVC Matching Grant FAO-A-0097-00049-00 Community Health project implemented September 1997—September 2000 in Bangladesh, Ghana, Indonesia and Zambia by the Salvation Army World Service Office (SAWSO). The evaluation was undertaken in the June-September period; with field visits conducted between June 21-July 22, 2000 to Palu in Central Sulawesi, Indonesia; Jessore, Bangladesh; and Chickankata, Mazabuka District, Zambia. The consultant, Laurie Zivetz, was accompanied by SAWSO staff Faye Hannah (Indonesia and Bangladesh) and Bram Bailey (Zambia). This report covers only the three countries visited; Ghana will be evaluated by SAWSO internally.

Although the period specified by USAID for analysis was 3 years, the same country projects received Matching Grant assistance in all four countries for the previous September 1995—August 1997 year period. Ghana and Zambia will continue to receive Matching Grant assistance for the next 3-year cycle. SAWSO will independently support the project at current levels in Bangladesh for another year and is discussing the provision of a package of Technical Assistance to Indonesia. The Matching Grant budget for each period was $1,800,000, with SAWSO contributing 50%.

1.1 Methodology

Prior to departure, the consultant reviewed all relevant documentation including the Detailed Implementation Plan (DIP), a DIP review, annual reports, and an internal evaluation of the project, conducted in 1996 in Indonesia and Zambia. Knowledge, Practices and Coverage (KPC) survey data was available for 1995, but the follow up survey, conducted in early 2000 in all countries was not consolidated until after the field work was completed, although some raw data was on hand in the field. A one-day briefing session with USAID and SAWSO as well as a daylong discussion with SAWSO preceded fieldwork. A debriefing with SAWSO was held 3 weeks after the field evaluation.

The team spent 5-6 days in each place, following more or less the following schedule:

Day 1: meetings with senior staff, site visits
Day 2: site visits (current and previous intervention communities): meet with volunteer health workers, groups of mothers, clinic staff, community health committees; discussions with project staff en route
Day 3: same as Day 2; meetings with local government officials; visit to other NGO offices/clinics (Bangladesh)
Day 4: meetings with project staff; prepare debrief
Day 5: debrief with project staff; drive back to capital city; meetings with USAID (Dhaka and Lusaka)

In-depth interviews, focus group discussions, documentation review, observation, and, in the case of Bangladesh where a skilled Bangla speaking facilitator was available, Participatory Rural Assessment (PRA) tools were all used to collect data. The consultant and SAWSO representative participated in all interviews and focus group discussions, with the exception of one session between the consultant and senior Salvation Army project staff in each country.

Debriefing notes were prepared and, following the debriefing session, given to local staff in each country. These are included in Appendix B of this report.

Excellent translation was provided by senior Salvation Army staff in all three countries. In addition, female facilitators joined the team in Bangladesh (Dr. Rita Sen, from PRIP Trust) and Zambia (Ms. Martha Museu from the Mazabuka District Health Office) and greatly enhanced candid access to female beneficiaries and health workers. External interpreters were also available in Indonesia and Bangladesh. While senior staff in Bangladesh and Zambia spoke English, this was not the case in Indonesia, where an interpreter was required for all discussions.

2. PROJECT OVERVIEW

The project under review builds on a history of Salvation Army (Salvation Army) provision of health services to the poorest members of society in developing countries, dating back to 1892. The Salvation Army is divided into Territories, which operate more or less financially and administratively autonomously. Each THQ (Territorial Headquarters) has links to the International Headquarters in London through the senior Salvation Army officer at THQ—the TC (Territorial Commander). Development activities of the THQ are typically operated in parallel with pastoral/evangelical activities under the overall supervision of the TC. Staffing, structure and decision making style vary considerably and have significant impact on project implementation and outcomes, as discussed in Section 7. SAWSO's Salvation Army partners function as indigenous NGOs in their respective countries, although all are linked through a shared organizational affiliation, mission and hierarchy defined by the Salvation Army. [1]

Because of the interlinked nature of its evangelical and development missions, the Salvation Army typically makes a long-term commitment to the communities in which it works. In all of the countries under review, curative services have and are still being provided to communities via hospitals, urban and rural outpatient, and mobile clinics. A community outreach approach remains a relatively recent innovation in the Salvation Army internationally. The Matching Grant support since 1994 has been used to underwrite a process of decentralization of services, a focus on prevention, information systems, community outreach, retraining staff, training a volunteer cadre, integration with other development activities, and a look at financial and programmatic sustainability.

The goal of the Matching Grant was: *to improve the health status of women and children in targeted communities in Bangladesh, Indonesia, Ghana and Zambia*.

The purpose is *to increase the capacity of local NGOs in those countries to develop, implement, monitor and evaluate sustainable community-based health programs.*

The program aims are stated as *to increase effectiveness and sustainability of local primary health care programs through: decentralizing existing Salvation Army community health services, promoting community ownership and involvement; designing systems for mentoring and evaluation that will be useful at all levels; and instituting fee for service and other strategies.*

Programs in the three Matching Grant countries evaluated are at various stages of maturity in the transition to community outreach and ownership, based less on the local context than on the history of support they have received from the local Salvation Army Territorial Headquarters (THQ) for this transition. What is common is that Salvation Army services in all the countries under review mirror government strategies. They are

[1] Not all development staff are members of the Salvation Army. For more, see Section 7.

being carried out in close cooperation with local governments, which also contribute medicines, immunization services, and in some cases part-subsidize Salvation Army hospital or clinic running costs.

The total target population for the Matching Grant was 132,000 (Bangladesh 36,000; Indonesia, 46,000; Zambia, 50,000), although in all countries preventative and curative services are reaching far more than this number[2]. Using just the target number of beneficiaries, the cost per beneficiary per year is $4.55. Quality of life indicators for all of the target areas are lower than national figures, though on average health indicators as at 1997 tend to be higher, based, presumably, on project achievements.

Overall, the Matching Grant initiative has operated as a series of parallel country-programs, with only minimal intersection and synergy at the SAWSO or country level. This is reflected in the way the project is described, the way results are documented, as well as the way SAWSO technical assistance and backstopping strategies have been implemented. This report will attempt to look at achievements on a comparative and country-by-country basis, and also to assess the extent to which this vertical approach helped or inhibited the impact of the Matching Grant overall.

While institution strengthening was a stated priority for the partner agencies, the project did not include a set of capacity building objectives for SAWSO itself. Nonetheless, because the project since 1995 has demanded new technical areas related to monitoring and sustainability, capacity building for SAWSO was, in some senses, implicit in the design.

2.1 Country Contexts

A variety of national, local and institutional factors inevitably color the progress and outcome of development projects. Key factors that may have influenced the Matching Grant program are touched on in this section by way of background to the analysis that follows.

Global trends

- International emphasis on prevention, decentralization of services, community participation, quality of care and women's empowerment;
- Recognition that the private sector—both NGOs and private providers—have an important role to play as partners with government;
- The Salvation Army, with a history of curative, hospital and clinic-based cost-free service delivery to the poor, moves towards community outreach;
- External donor and internal Salvation Army International funding of health and development programs shrinking, providing immediate incentives for cost-recovery and cost-cutting measures;

[2] In Bangladesh, for instance, the number clients to the central Jessore clinic from Matching Grant areas is about 50% of the number of clients from non-Matching Grant supported areas.

- The Salvation Army enjoys an excellent reputation and relations with local governments;
- The logistics and cost of transportation are major challenges to project implementation and sustainability in countries with poor infrastructure or dispersed populations.

Country Trends and Salvation Army history

Bangladesh

- The government doorstep family planning and Maternal Child Health (MCH) programs, which have been highly successful in reducing fertility and morbidity rates, are being consolidated, phased down, and replaced by standing clinics;
- USAID is a major donor/player in this process;
- The Salvation Army launched its program in Bangladesh just after independence in 1971 as emergency relief, following flooding;
- In addition to running a clinic in Jessore, the Salvation Army has successfully replicated the original doorstep program in the surrounding catchment area, where it is the designated government family planning service provider.

Indonesia

- The impact of the Asian economic crisis has been felt at local levels, although a government instituted safety net program--scheduled to phase out in 2000--provides free health care for a large number of residents in the Salvation Army catchment area. Rural residents less affected by the crisis;
- The Salvation Army has operated in Indonesia for more than a century, launching its activities in Central Sulawesi in 1974 with a hospital and nurse training facility at Palu, and up to a dozen rural clinics, some in remote areas still not reached by government services;
- Government directives, coupled by reductions in Salvation Army staff and resources, have led to reductions in the number of communities reached by the Salvation Army over the last 6 years.

Zambia

- Downturn in copper prices, regional drought, cattle disease and HIV/AIDS have significantly impacted on livelihoods and the social fabric;
- The Salvation Army has been in Zambia since 1945 and runs a 200 bed teaching hospital, 4 rural health centers, 42 village clinics and a training center primarily for community-AIDS training at Chickankata, 1.5 hours south of Lusaka;
- Salvation Army Chickankata HIV prevention and home-based AIDS care and counseling program seen as a model in Africa.

3. HEALTH IMPACTS

This chapter reviews the major achievements of the program in reducing morbidity and changing awareness, attitudes and behaviors against the original objectives of the project. These outcomes were achieved largely by means of a community outreach strategies (backstopped by Salvation Army hospital and clinic facilities), which are reviewed in more depth in the following chapters. Table 1 includes key indicators. The comments in this Table are SAWSO's, based, in part, on discussions with country office staff. In some senses the data provides as much of an insight into the orientation of the country office and maturity of the community outreach program, as it does actual achievements and outcomes.

Although other data was collected as part of routine monitoring and reporting, the KPC data was used to establish targets for the project in 1995 and to measure change against this baseline in 2000. Sample size and sampling methodology preclude statistical rigor, which would validate precise changes in these indicators, but it, does benchmark knowledge, attitude and behavior change.[3] For more details on the KPC, see Appendix C. Most of the data in Table 1 is drawn from the KPC

[3] During briefing discussions with USAID and SAWSO at the outset of the evaluation, it was agreed that the KPC could be used in the evaluation in this way.

Table 1: Impact Data: SAWSO Community Health Project

A. Nutrition

Objective	Target	1995	2000	Comments[4]
? **Exclusive Breastfeeding 0-4 months**				
Indonesia	90%	59%	62.5%	The outcome is low because mothers continue to give their children water in addition to breast milk. They make a distinction between "feeding" food and "feeding" water. The KPC question about when a child should be given food in addition to breast milk confirms this finding.
Bangladesh	85%	76% 0-4mo	50% 0-6mo	Age groups not comparable. Results for age group (0-4 months) will be reported from the computer tabulation.
Zambia	76%	37%	63%	Increase is due to this being a major focus of Under 5 Nutrition program
? **Introduction of foods: 5-8 months**				
Indonesia	80%	66%	94.4%	Low outcome may be due to the impact of the economic crisis on food purchasing, as many families in the project area depend on wages for income.
Bangladesh				Different from breastfeeding because exclusive bf was calculated at 6 months rather than 4 months.
Zambia	76%	69%	69%	In the past 5 years, Chickankata has suffered at least 3 major droughts and diseases have killed most of the cattle, which has resulted in the collapse of the farming industry. It is difficult to push the introduction of food when it is not available. We are fortunate that this figure has not gone down. Reason: due to the outreach program's promotion of the importance of introducing foods.
? Vi**tamin A coverage**				All governments introduced a Vitamin A capsule supplementation program during the life of the Matching Grant. Targets, set in 1995, were for food.
Indonesia				MOH provides capsules at mass immunization campaigns. Promotion of Vitamin A capsules began after 1995.
Bangladesh	80%	62%	84.7% food 98.2% caps	Capsules given out at mass immunization/Vitamin A campaigns.
Zambia	94%	84% food 19%	51% food 97%	Initially Chickankata focused on increasing the use of foods rich in Vitamin A. However, the strategy changed to capsules when the government introduced an aggressive Vitamin A capsule program.

[4] All comments in this Table are SAWSO's.

		caps	caps	
? **Children gaining weight**				
Indonesia	75%	56%	64%	
Bangladesh	85%	75%	84%	Data for weight gain was taken from 1999 annual report.
Zambia	N/A			

B. Diarrhea Management

Objective	Target	1995	2000	Comments
? **Diarrhea incidence**				This was not a target, but can serve as one indication of the impact of this component of the project.
Indonesia		N/A	33%	
Bangladesh		33%	13%	
Zambia		41%	36%	Increase in the number of clean wells and dams as well as increase in use of pit latrines have helped reduce the incidence of diarrhea, despite the high rates of HIV/AIDS
? ORT Use				
Indonesia	80%	45%	77%	Although diarrhea incidence was 32% at the time of the survey, 96.5% of the target was achieved because ORT use--especially ORS packs and SSS solution--are the most population intervention in diarrhea management. Packets were available and affordable, and the project placed increased emphasis on ORT use at onset of diarrhea.
Bangladesh	85%	70%	100%	Outcome is high because ORT encompasses ORS packets, SSS solutions and home available fluids. Also: use of packets and SSS is a very popular intervention in diarrhea management. Packets were available and affordable, and the project placed increased emphasis on ORT use at the onset of diarrhea.
P Zambia	75%	63%	78%	Increase is due to this being a focus of the under 5 and nutrition program, coupled with increased supply of ORT packets to outreach staff and community volunteers.
? **Continued food during diarrhea**				
Indonesia	90%	76%	56%	The drop is due to a) the difficulty of convincing mothers that children should be fed during diarrhea; b) difficulty in providing enough food due to the economic crisis; c) acceptance of the concept of giving fluids; d) popularity of ORS packets and SSS.
Bangladesh	70%	58%	66%	Low result is because it is harder to convince mothers to continue food than to give various kinds of fluids as above. Given the low 1995 rate, a 7% jump is respectable.
Zambia	N/A	41%	40%	This behavior was not targeted and is difficult to change because women find it very difficult to force their children to eat when they are sick.
? **Increased food after diarrhea**				
Indonesia	25%	0	31%	No baseline. ORT use also high, see above.
Bangladesh	85%	65%	70.3%	ORT is higher than other practices for reasons listed above.
Zambia	40%	40%	79%	This behavior was a focus of the program and is easier to achieve because children are hungry and there is less need to force them to eat.

C. Immunization Coverage

Objective	Target	1995	2000	Comments
? **Total coverage for children 12-23 months**				
Indonesia	60%	34%	36%	Since 1997, the government has gradually taken over responsibility for immunizations and provides very few vaccines to NGOs. In addition, there are some project communities where the MOH has not sent immunization teams for over a year.
Bangladesh	95%	86%	99.6%	83.6% was found at KPC: possible a tabulation error as annual reports from 12/98 through 12/99 show complete coverage at 99.7% and 99.6 respectively, or 104% of the target. This finding will be crosschecked with computer tabulation.
Zambia	Maintain 75%	75%	82%	Because it was envisioned that the reorganization and expansion into new areas might cause coverage to decline and immunizations were already high, the target was to maintain. The program was successful in reorganizing, expanding, and increasing coverage rates.
? **Increased access to DPT1**				This is typically used as a proxy for access to immunization.
Indonesia	75%	58%	74%	Although NGOs are provided fewer vaccines by MOH, the Salvation Army is able to give DPT1 at first post-natal visit to Salvation Army clinics. Other immunizations are generally obtained during MOH team visits.
Bangladesh	95%	90%	86%	86.3% found at KPC. Hand tabulation results will have to be crosschecked with the computer tabulation results.
Zambia	75%	72%	91%	The KPC identified areas that had no access, and the program expanded services to these areas.
? **Decreased drop out rate**				
Indonesia	10%	34%	36%	The drop out rate is expected to increase now that the MOH has taken responsibility and control of immunizations. Complete coverage requires that children receive all antigens (DPT2, DPT3, measles) and that mothers bring their children for government immunization days.
Bangladesh	Maintain less or equal to 3%	3%	Unknown	Drop out rate will have to be re-calculated when computer tabulation is available.
Zambia		14%	2%	As above, it was envisioned that the reorganization and expansion into new areas might cause coverage to decline. The program was, however, successful in reorganizing, expanding and decreasing the drop out rate.

D. Reproductive Health

Objective	Target	1995	2000	Comments
? **Antenatal care**				
Indonesia	90%	75%	98%	The achievement of this target was due to: a) the drop in the number of project sites from 46 to23 due to sustainability planning. Government services were available in these sites. This reduced costs by 50%; b) SA antenatal care services are perceived to be of higher quality than government services.
Bangladesh	90%	81%	90%	Doorstep AN services are responsible for consistently high results.
Zambia	40%	30%	85%	Expansion of services and more consistent availability of services through the mobile clinics and the training of volunteers resulted in the increase of expecting mothers making at least one antenatal visit during their pregnancy.
? **TT coverage, pregnant women**				
Indonesia	70%	55%	82%	TT immunization is provided during visits to the Salvation Army antenatal clinics.
Bangladesh	90%	80%	80%	Lower level of TT coverage compared to AN coverage is probably because the SA staff are responsible for AN care. Immunizations are the responsibility of the MOH.
Zambia	20%	12%	66%	As above, expansion of services and more consistent availability of services and an emphasis on getting mothers to make ante-natal visits where they receive TT injection.
? **Delivery by trained health worker**				
Indonesia	80%	64%	90%	The reasons for the high achievement are: a) trained TBAs available; b) SA delivery services, including hospital services, are perceived to be of superior quality to government services. Although the government has stopped focusing on TBAs in favor of certified midwives, implementation of this change has been slow and most women still rely on TBAs.
Bangladesh		70%	81%	Increase is probably due to the influence of VHWs, the availability of trained health worker (TBAs in particular); the perception that the SA offers quality delivery services.
Zambia	16%	6%	38%	This target was set low based on the low numbers from the 95 KPC. With all the services provided and volunteers trained by Chickankata, these findings were unexpectedly low. The strategy was to find out the reason and address the causes. One reason was that volunteers were being underutilized because the outreach team did not include support to volunteers as part of their service delivery role. Now they see their work as supporting the volunteers and only providing services that the volunteers cannot provide.
? **Modern contraceptive use**				

Indonesia	90%	81%	93%	71% of women interviewed did not want a child in the next 2 years. The Indonesian government has been promoting family planning for years.
Bangladesh	80%	63%	80.7%	Contraceptive use nationally ranges between 65% and 75%. The Salvation Army, which is fully responsible for FP service delivery in the project catchment area, has twice received national recognition for their success in FP.
Zambia		32%	50%	Although no target was set initially, the Chickankata team was able to get community health workers trained as community based distributors and began an aggressive promotion program.

E. Acute Respiratory Infection

Objective	Target	1995	2000	Comments
? **Skilled help sought for ARI**				
Indonesia	75%	61%	80%	Health education about ARI has focused on the danger of ARI and the need to get skilled help quickly.
Bangladesh	90%	62%	89%	Target was achieved because health education by VHW's focused on increasing mothers' knowledge about the S/S of pneumonia
Zambia	75% Knowledge	77% Practice	79% Practice	In light of increasing incidence of HIV/AIDS, the program focused on maintaining the practice of going to a health professional to treat ARI. The team feared that practice would drop. Fortunately it did not.

F. HIV/AIDS

Objective	Target	1995	2000	Comments
? **Awareness of sexual modes of transmission**				
Indonesia	30%	7%	17%	To date no HIV/AIDS has been seen in the project area.
Bangladesh	85%	50%	57%	The small increase in knowledge is probably because people are not seeing cases of HIV/AIDS in their villages yet.
Zambia	60%	47%	55%	Despite the fact that there has been an increasing knowledge about the modes of HIV/AIDS transmission and many cultural taboos about discussing sex have been lifted, it is unlikely that in a context where one out of five is HIV positive, only 55% would know the main mode of transmission. The Chick team feels that there is something wrong with these findings and is planning to do a study focusing specifically on HIV/AIDS knowledge and practice.

An overview of the data reveals some noteworthy trends:

- MCH outcomes are impressive in terms of maintenance as well as change in key behaviors and access to preventative services;
- Vitamin A capsule campaigns, introduced by governments in all three countries during the second cycle of the Matching Grant, pre-empted behavior change motivation for food consumption, except in the case of Bangladesh where it remained more or less the same;
- Denial and embarrassment may be responsible for low reporting of awareness of sexual modes of HIV transmission among respondents from all three countries, particularly Zambia, where the prevalence of the disease is so high. The Salvation Army and JHU may need to revisit this question in the survey;
- Most of these results were achieved by community-based health workers backed by stationary and mobile clinics as well as cooperation with government;
- The relatively higher achievements in Bangladesh may relate to the well-established community health outreach program as well as the fact that community health workers are paid;[5]
- The two Asian offices tended to set targets high, reflecting to some extent achievements at the time of the 1995 baseline.

Noteworthy country specific outcomes are as follows:

Indonesia

- Disappointing results in immunization coverage, attributed to government inefficiencies, may have been addressed with data from an informative MIS system and a more proactive project management team liaising with government, addressing gaps, and reinforcing follow up.
- Access to immunization, as measured by DPT1, reached targets, but immunization dropped off significantly following this. Although SAWSO attributes this to deficits in availability of vaccines from government, this merits more investigation. Certainly a case could be made for increased advocacy to government, if this is indeed the case. The role of village health workers in immunization is relevant in this regard: did they alert rural clinics or Salvation Army staff of these deficits?
- High rates of antenatal care are directly linked to the *posyandu*[6] system, which provides a focal point for pregnant women, mothers and village health workers.

[5] The implications of both of these findings for design, cost and sustainability although as yet not researched, merit greater investigation. Existing data would allow this to be done on a country-specific and comparative basis, as recommended in this report.

[6] The *posyandu*, an innovation of the Indonesian Government health system which is central to MCH prevention in the country, involves a combination of baby weighing, health and nutrition education, and can also include ante and post natal check ups, immunization and other basic services. Typically convened by a village health volunteer and/or village midwives, local clinic staff provide back up and referral services.

Bangladesh

- High baseline and outcome indicators rely on a well established and managed network of community health workers;
- Bari mothers, tasked with distributing ORS packets, may be overemphasizing this popular treatment at the expense of other, less externally-dependent treatments;
- The peri-urban nature of the population and its proximity to facilities coupled by the active work of CHWs and Bari mothers is responsible for near-complete immunization coverage;

Zambia

- Immunization and behavior change communication coverage appears to have been improved with strengthening of the community outreach program.
- Achievements in this regard are particularly impressive when the impact of HIV on health and the social fabric are taken into account.
- Incases in family planning are due in part to John Snow, International (JSI) volunteer training.

4. COMMUNITY OUTREACH: STRATEGIES AND ACCOMPLISHMENTS

The project's community outreach approach relies on support to a cadre of volunteers and the establishment of community health committees. Each country program was designed, structured and implemented somewhat differently. All grappled with issues of health worker training, supervision, motivation, attrition, and, to a lesser extent, gender. The seeding and support of community health committees was seen as a sustainability and empowerment strategy. Monitoring and information management was designed to be an integral aspect of the community outreach program in each country as discussed in Section 5.

4.1 Community Health Volunteers

In all three countries, the volunteer program preceded the Matching Grant. Community volunteer *kadars* have been integral to Indonesia's MCH program for several decades. Village Health Workers (VHW) and Family Planning Workers (FPW) (albeit paid) have been responsible for the dramatic drop in Bangladesh's growth rate, and strides in MCH. The Salvation Army/Bangladesh introduced the volunteer *Bari* mothers who supplement the grassroots work of the VHW and FPW by providing information and oral rehydration solution (ORS) in the treatment of diarrhea. In Zambia, community volunteers were introduced in the mid- 1980s to compliment mobile teams, which had been extending the hospital's reach to communities since the late 1970s. There is an analogous system of government community based volunteers. In all countries, training of Traditional Birth Attendants (TBAs) is part of Salvation Army and government schemes.

Although the project did not launch or innovate significantly on programs already in place, the attention and resourcing of the volunteer aspect of the program that the Matching Grant enabled was responsible for important health impacts of the Matching Grant as discussed in Section 2 above. Asked to reflect on changes in health status over the last decade, beneficiaries interviewed in this evaluation universally saw positive change and identified improvements in awareness and practice, particularly to do with child health and nutrition, birthing practices, hygiene, and family planning. PRA exercises, in which mothers were asked to diagram key sources of health information and basic services, cited the community-based volunteer/worker among the top 1-2 sources in Indonesia and Bangladesh.

The volunteer/worker assumes an important role in on-going prevention activities, such as the *posyandu* or monthly baby weighing event in Indonesia. S/he treats minor emergencies such as childhood diarrhea or cough. In many cases, s/he accompanies patients to clinics or hospitals in times of crisis. As a result, the village health worker has become a valued part of the social fabric in many communities, with positive implications for sustainability and gender as discussed below. Volunteers and community-based workers also collect basic health-related information, and provide a

potential conduit for information analysis and sharing between health facilities, the project and communities (discussed in Section 5.1).

Training was universally acknowledged as an important incentive to volunteers. Training empowers volunteers with information and skills, the opportunity to share and receive feedback on problems and accomplishments, and a direct interface with the project. It also confers the status accompanying paid travel to a venue beyond the borders of the village.

The timing and location of training can also determine who becomes a volunteer. In Zambia, husbands' unwillingness to "allow" wives to leave their household duties to attend a training of several weeks was cited as the main reason that more than 95% of village health workers (and a majority of CPT—Care and Prevention Team--members) are men. This did not appear to be an issue in the other countries.

Training can also be one of the most expensive parts of a volunteer program. The Indonesia program plans to take the training to the village, thereby reducing travel and related expenses of large, centralized training events.

The Indonesia program modified the government-training curriculum, based on trainee feedback, making it at once more participatory and audience appropriate. The modifications were made by staff who had attended short courses in North Sulawesi, sponsored by the Matching Grant. In Bangladesh and Zambia, the Salvation Army has its own training curriculum. In all cases, refresher training is scheduled more frequently than government (typically once or twice a year). The Bangladesh program suspended training for an entire year while its training center (a centerpiece of its income earning sustainability strategy) was being constructed. To recover lost ground, 2000 is being billed as a training year.

SAWSO appears to have had only minimal input into training curricula or training methodologies, whether because government curricula were available or because they were not asked. UNICEF's *Facts for Life* curriculum was provided to the Salvation Army in Indonesia, but appears not to have been adopted.

Supervision is also an important incentive to volunteers. Supervisors, who are paid project staff, are responsible for on-site support, problem solving, data collection and collation. In Zambia and Indonesia, because of the cost of transportation, mobile team members double as supervisors, meeting with volunteers during community clinic periods. In Bangladesh, Village and Family Planning workers backstop *Bari* Mothers and TBAs.

In Indonesia, the number of supervisors has all but evaporated, with staff claiming they have had problems in recruitment. Interestingly, a veteran VHW—an older woman beyond her childbearing years—expressed enthusiasm to the team when presented with the idea of becoming a supervisor. Two community health workers in Bangladesh

have recently been promoted to supervisor positions. Perhaps Indonesia failed to look to the community for help? In all countries, volunteers have links with local clinic staff who accept referrals and, in Indonesia, attend *posyandu* sessions.

Sustainability is, inevitably, the key issue in a volunteer program. Success is measured as much by how volunteers perform during the life of a project when they are actively engaged in meeting project objectives, as how they perform 5, 10 and more years after this flurry of activity has died down or disappeared. In visits to such communities in Indonesia and Bangladesh, the team found that some volunteers have continued to provide information and basic services, with the support of their communities and local clinics: a testimony to their motivation, and value to beneficiaries. By contrast, in nearby communities not reached by Salvation Army health volunteers, government volunteers and even paid community-based workers do not appear to have developed the relationship and trust of communities that characterize Salvation Army volunteers.[7] Most government employees and volunteers have greater workload and fewer incentives.

Recognition of their value to communities comes to volunteers in the form of remuneration and enhanced prestige. Communities in Zambia donate grain and labor to allow volunteer health workers to hold clinic hours, even during busy agricultural seasons; *posyandu* participants in Indonesia contribute a fee to ensure continuation of monthly baby weighing and health education sessions. Many volunteers have assumed leadership positions on community committees and other decision-making bodies.

Asked what keeps them going, health volunteers in all three countries talked about the satisfaction they receive from being able to serve their communities, the relationship and trust it has built with their neighbors, and the access to information and training it has offered them. In all cases, volunteers received token incentives from the project (in addition to training) such as clothing. In Indonesia a *kadar* enjoys free access to health services. In Bangladesh, the Salvation Army is considering a credit program for VHWs and *Bari* mothers.

*S*alvation Army offices in all three countries appear to be wrestling independently with the related issues of how to optimally select, train, motivate and integrate volunteers into their community outreach programs. The success of the volunteer program to date suggests that efforts to more systematically research these issues could be valuable for

[7] These assertions are made on the basis of a handful of interviews conducted with beneficiaries, volunteers, and clinic staff in project and non-project sites, and the testimony of Salvation Army field workers.
On the other hand, in Bangladesh, in several villages where the Army operated until 10 years ago, villagers have resorted to using what they refer to as the "Quack" (a healer who typically worked alongside a doctor or pharmacist before putting up his own shingle in the village). Villagers in this and other places said they like the "Quack" because he (and they all appear to be men) is always available and gives medicines on credit. A missed opportunity for the project perhaps?

fine-tuning, replication, scaling up, and advocacy.[8] It would also suggest this to be a topic meriting greater inter-country dialogue, which has been absent in the past.

4.2 Community Health and Development Committees

Project staff in Bangladesh and Zambia attributed the impetus for the establishment of community health committees to the Matching Grant. In Indonesia, village health committees had been established under a government initiative, with mixed results. Project efforts to revive these committees or create new ones did not succeed. It appears that currently in Indonesia health concerns have been incorporated into traditional village based leadership structures by including of *kadars* who have shown leadership qualities into these structures.

Community Support Groups were established late in Bangladesh, beginning only in January of this year. They appear to be large, somewhat unfocused, and will likely need a good deal of skills training, guidance and partnership support from the Salvation Army to survive. Nearly two dozen Care and Prevention Teams (CPTs) have been established in Zambia over the last four years, evolving, as their designation implies, from the Salvation Army's focus on HIV/AIDS prevention and community-based care. Their tasks today are much broader.

Committees in Bangladesh and Zambia are constituted of village leaders, politicians, teachers, health workers, health volunteers and business people. Membership ranges from 20-30. Project staff had a greater role in determining committee membership in Bangladesh than in Zambia, where the Salvation Army staff were consciously careful to allow communities wide berth in the selection process to the community.

Community and project expectations of the community committees range from:

1) providing a forum for discussing health, development and economic issues;
2) taking responsibility for managing and remunerating health and development volunteers;
3) social action, such as prompting parents to send children to school (Bangladesh), hygiene, agroforestry (Zambia);
4) resource mobilization and care for the sick, poor or orphaned members of the community (Zambia);
5) accessing external resources for community infrastructure (Zambia).

The Salvation Army/Zambia has developed an impressive curriculum for CPT training, including aspects of resource mobilization and management, PLA, proposal-writing, community counseling and conflict resolution. The project also holds seminars with groups of CPT representatives on a twice-yearly basis, which serves to impart more

[8] Because of the longevity of the CHW/community volunteer program in Bangladesh, the extent and richness of the available data, and the in-country research capacity, the Evaluator recommended that a study of the costs and health impacts of community health/volunteer workers be carried out.

skills, network CPTs with each other, monitor issues, and identify where additional support is needed. Project staff also visit CPTs on a regular basis.

Lacking a framework or guidance for this type of community development work at the organizational level, the process of seeding, supporting and partnering with what are essentially potential community based organizations, has been a process of trial and error for the Salvation Army offices in the three countries. Achievements thus far in Bangladesh and Zambia have relied on three things:

1. the trust communities have in the Salvation Army, given the agency's longevity and generosity in the target communities;
2. the quality and commitment of development professionals leading the programs in the field; and--to a lesser extent,
3. networking with other development NGOs in their own countries.

Ironically, the Salvation Army's profile in the communities has been as much an enabling factor as a stumbling block, as communities are confused, and sometimes resentful that they are being asked to assume the burden of responsibility for services and decisions which for so long have been borne by the Salvation Army. As a senior team member in Bangladesh put it: "What we should have done first, we did last. Community participation should come first. But this was not the way in the Salvation Army in the past. The approach has changed." The transition has required the Salvation Army to engage in a new kind of dialogue with communities, supported, in some cases, by the existence of community committees.

The establishment of community committees raises another, longer term issue in terms of the extent to which these committees—created with a development agenda—compete, compliment or interface with community-level Salvation Army corps which have an evangelical focus. This will be taken up again in Section 7.

SAWSO's role in the conceptualization stage of committee formation in Bangladesh and Zambia is clear. In Zambia in particular, staff credit SAWSO with this innovation, which has become a centerpiece of the program. SAWSO has also provided on-going encouragement to all offices. The extent to which SAWSO has offered technical assistance, best practice input and linking with other NGOs involved in building community based organizations, is less clear.

4.3 Mobile Teams

The scattered and remote nature of target communities in both Indonesia and Zambia coupled by the absence accessible health clinics, has led to the creation of mobile clinics in both places. In Indonesia, where mobile clinics were sometimes the only health services available aside from Salvation Army-trained volunteers, staff also provide hands-on training and mentoring in latrine construction, vegetable and medicinal herb garden extension and agricultural production in addition to routine health and nutrition education and services. For remote communities, the team only visited

four times a year, whereas in closer communities it averaged once a month. In Zambia, the mobile clinic combines a once-monthly opportunity for people to gather for immunization, ante and post natal care, health education, on the spot preventative services as well as volunteer support, data collection and monitoring. The cost of transportation is a major factor in both countries.

Mobile Clinics have undoubtedly had an impact on health status by bringing services and information to communities. A closer comparison of the composition, costs and impacts of this approach vs. community-based volunteers and fixed clinics—all part of the constellation of services in both countries--would inform future sustainability planning.

4.4 Gender

Although gender equity was not an explicit objective in the DIP, it is a well-established determinant of any successful health, community outreach or development program. Neither the DIP, discussions with SAWSO or project staff in the field revealed any serious attempt to analyze the nature of household and community resource allocation or decision making from a gender perspective. These factors have everything to do with health and health seeking behaviors and practices and are, inevitably, albeit often inadvertently, impacted upon by development interventions. A gender-sensitive program models gender equity in its staff as well as the way resources and information flow to beneficiaries.

The evaluation was able to identify only two instances[9] of intent to address gender in the context of program implementation, in a broader sea of missed opportunities and no clear commitment or direction in this regard. At the field level, project management in all countries is entirely male. In Asia, volunteers are primarily female, but their supervisors are predominantly male—a fact that may be responsible for chronic understaffing of this position in Indonesia, as mentioned above. In Zambia, nearly all volunteers except TBAs are male. While staff and volunteer cadre composition is not the only indicator of a gender sensitive program, it does send a strong message to communities about how seriously the project takes its own rhetoric in this regard. At the community committee level, female representation was typically limited to female health workers—progress, but how much?

Reasons given for this gender imbalance related to the perceived inability of women to travel (for training, for work) the domestic demands on women's time, and lack of husband's permission for wives to travel. Based on informal discussions with women encountered during this evaluation, and innovations in other programs in the same

[9] Two Village health Workers in Bangladesh had recently been promoted into a pool of heretofore all male supervisors; it was suggested to CPTs in Zambia that 50-50 composition was optimal. The latter does not appear to have eventuated. Local Salvation Army staff in Bangladesh also brought in an external NGO to provide gender and legal rights training to staff.

countries, it is clear that the cultural and programmatic potential was there to do more in raising and addressing these issues. For instance: the KPC data for Zambia indicates that 47% of women travel outside the home for work. The fact that village health volunteers are being remunerated in-kind challenges traditional assertions as obstacles. In Zambia, the 1997 DIP states that volunteers were not being used as the first point of contact in the case of simple disease such as childhood diarrhea. It also points to the discrepancy between mother's basic knowledge and practice of basic health and nutrition behaviors as a flaw in the health education approach. The fact that female beneficiaries are by-passing community volunteers in Zambia may have as much to do with the sex of the provider than any other factor—a hypothesis that merits further investigation.

As mentioned above, health volunteers have gained status and a voice in community decision making through the support this project has provided them. [10]

Although decisions on the gender of community volunteers were made more by default than design (in Asia almost all community health workers are women because of privacy taboos related to reproductive health issues), such decisions have clearly impacted on power and prestige.

SAWSO's role in initiating the dialogue on gender in the design and implementation of the Matching Grant, in monitoring and advocating gender equity in recruitment of paid and volunteer staff, and even insisting on intentional inclusion and quotas in strategic aspects of programming (such as community committees) merits more attention.

[10] SAWSO staff have observed that many women volunteers who received training and supervision from the project, are now more assertive and engaged in community decision making processes.

5. Information and Documentation

5.1 Management Information Systems: objectives and achievements

Objectives anticipating improvements in the use of information for planning, monitoring and evaluation are included in DIPs and other documents for all countries in both cycles of the Matching Grant. Overall, despite that fact that data is being effectively collected in Indonesia and Bangladesh, and exciting steps have been taken in systems design in Zambia, progress in effective use of the data has not met original targets for any of the countries.

In the Asian sites, data is gathered largely for government and donor reporting purposes.[11] Village Health Workers in both countries said they use the data they collect for monitoring individual mothers and children, but appear to lack the skills and understanding to be able to analyze, graph or present trends. Although they may have a "feel" for health trends in their community, the ability to analyze data would significantly advance the precision of their understanding, not to mention their credibility and leverage with village committees and health providers.

Supervisors and other managers were reported by SAWSO to use data for planning or assessment purposes. This does not appear to occur in any systematic way, though local managers continue to articulate the need to do so.

In Zambia, the Health Information Management System (HIMS) of the government, which is being adapted in an attempt to integrate the hospital, clinic and community programs, remains, as in 1996 during the Mid-Term Evaluation "…almost operational". Nonetheless, the Salvation Army/Zambia has taken the challenge seriously, devoted staff resources to the job, and addressed itself to issues of collection procedures, forms, supervision, collation, ownership, community feedback etc.—issues which all participating Matching Grant countries are grappling with. When it is operational, the HIMS at Chickankata will be capable of monitoring disease trends, health seeking behavior, locating anomalous situations, costs and revenues, with interface between the three components of the health delivery system.

Technological, technical expertise, software limitations, as well as geographical present real and legitimate obstacles in the development of appropriate MIS systems. However, given the fact that all programs (including SAWSO's) are being run by health professionals, not statisticians, it is possible that the input of external technical assistance—including a look at software requirements--early in the program, would have resulted in greater progress.

SAWSO appears to have made limited use of country-level data for charting trends, comparing country programs, identifying anomalies, calculating impact and developing

[11] Typically, government supplies medicines to NGOs based on these reports.

measures of sustainability. Data presented in Section 3 relies almost exclusively on KPC outcomes—interesting and rich, but not by any means all that is being generated at the country level.

Sharing of experience and expertise across countries—particularly from Zambia where the system is the most evolved, could have energized and informed all four countries participating in the Matching Grant, and most likely led to greater progress on all counts. Capacity building in Management Information Systems design has fallen short of expectations.

5.2 Special studies

In 1995, at the outset of the first Matching Grant, SAWSO staff were trained by Johns Hopkins' School of Public health to undertake a Knowledge, Practice and Coverage Survey (KPC). Partner staff in the four Matching Grant countries were then trained and instruments adapted to the local context. The KPC was carried out in 1995, and again in 2000. The implementation of the KPC may have done more to empower and raise understanding of information management than any other activity related to data management over the life of the Matching Grant. Local Salvation Army staff collected and in the second round independently analyzed the data. In some cases data was shared back with sample communities. Other Salvation Army countries have replicated the KPC as well.

Although only one other special study was anticipated in the DIP, the quality of longitudinal and comparative data available to Salvation Army partners, particularly in Asia, would suggest that more could have been done to document and cull lessons learned from experience.

In Bangladesh, a front-runner among the countries visited in terms of sheer volume of data, clinic staff routinely note whether patients are from Salvation Army outreach or non-outreach villages. Although this data is collected primarily to inform requests for government-supplied medicines, it is a potentially powerful indicator for contrasting disease patterns and health seeking behavior in communities with active Salvation Army volunteers against control communities.

In both Bangladesh and Indonesia, changes in health practices, attitudes and outcomes were monitored using monthly and KPC data. When analyzed in conjunction with cost information for Community Health Worker programs, could be powerful in analyzing the cost-impact of the CHW program. This kind of study, be carried out by a local a University or NGO, could be used for advocacy, profiling, and, importantly, sustainability projections. The same kind of analysis in Zambia could inform decisions on structure and staffing (discussed in Section 7 below), sustainability and integration issues, particularly vis-à-vis costs, impacts and revenues.

The 1995 DIP anticipates a comparative study of the doorstep family planning program with the newly introduced clinic-based program in Bangladesh: a current and controversial issue in Bangladesh. The Salvation Army, like many NGOs, has successfully implemented the doorstep program under government auspices for many years. Given the data available to the Army (including attitudinal data from the KPC and information from non-project areas), and links with outspoken and influential government officials advocating for both sides of the debate on this change, it is disappointing that nothing was done about the proposed study. The reason given was that another agency is already conducting a similar study.

6. SUSTAINABILITY

In the transition from the first cycle of the Matching Grant to the second, an emphasis on sustainability emerged as the major change. Now, in addition to hospital and clinic-based curative services, which the Salvation has traditionally offered, the Matching Grant countries have introduced preventative programs through community outreach. These strategies were designed to affect a shift in responsibility and "ownership" to the community—to empower and inform, and to create partnership where historical dependencies exist. They were also about cutting costs and increasing revenues. Each country adopted slightly different strategies including:

- Reviewing inventory, acquisition and control of pharmaceuticals (Bangladesh);
- Increasing fees for services and medicines (all countries);
- Cutting recurrent costs, especially for transportation and mobile clinics (Indonesia and Bangladesh);
- Building skills/revenues at the community level for people to address their own problems through volunteers and community health committees (all countries);
- Insurance schemes (Zambia, Indonesia);
- Integration of community health with other development activities (Bangladesh and Zambia; Indonesia has an agricultural extension agent as part of the Matching Grant initiative but also a stand-alone agricultural project in Palu working in non-Matching Grant sites);
- Continuing or expanding access to government supplies (all countries)
- Salvation Army hospital subsidizes community outreach activities (Indonesia[12] and Zambia);
- Building a training center for rent (Bangladesh);
- Remaining in the catchment area indefinitely (all countries);
- Income generating activities for CHW's (Bangladesh).

Progress was made on all counts during the Matching Grant period. The Matching Grant assisted in underwriting the on-going transition to community outreach in all countries, which has proven particularly valuable in reorienting the Salvation Army's relationship with communities.

While each specific strategy has its own merits, and country offices have taken steps towards the achievement of many of these targets, as a whole they represent a series of haphazard responses to larger institutional, sociopolitical, and fiscal realities, which received little analysis and no coherent guidance from SAWSO over the life of the project. Although this was a target of the program in all countries and at the program

[12] In fact, the Salvation Army hospital at Palu has been subsidizing rural clinics for some time, though this was not stated in the DIP or previously known to SAWSO.

level, at the end of three years there is little to show in terms of a strategic framework, sustainability guidelines for the field, or even a retrospective cross-country analysis of lessons learned.

It is curious that, given the emphasis in the last Matching Grant on sustainability, this kind of overarching strategy was not part of the DIP, which was, in fact, organized as a series of country-specific DIPs, with no overarching program strategy section—a serious omission on several counts. While this lack of a broader analytical and development framework is not entirely unique in the NGO world, it is unfortunate that SAWSO did not take advantage of the opportunity offered by the Matching Grant to initiate a more systematic analysis of potentials, opportunities and risks. This kind of planning process could have worked with and refined an institutional model for sustainability and, perhaps as importantly, addressed some of the tensions, which the sustainability debate raises for an organization like the Salvation Army (an issue addressed in more detail in Section 7).

Given the absence of a comprehensive sustainability strategy for the Matching Grant, it is disappointing but not surprising that none of the country offices undertook to develop their own sustainability plan.[13] What *is* surprising is that USAID did not request this as an output (or at very least an indicator of capacity building) at the DIP negotiation stage.

Having said this, there is, on a practical level, a palpable concern in all country offices about sustaining current community outreach activities while maintaining quality into the future. The Matching Grant in all cases was part of a portfolio of projects supported by a variety of international donors, and, to a lesser extent, local government and the Salvation Army International Headquarters[14]. Although all offices have increased fees and Zambia recently launched a promising insurance scheme, dependence on external donors will continue into the foreseeable future. Health services—and particularly community outreach services--are unlikely to ever achieve total financial self-sufficiency (or, for that matter, complete community mastery) anywhere. The search for new or on-going external donors seems like a reasonable response, with its accompanying risks. It does, however, set up the same external dependency, which country offices are urging communities to move away from. A conundrum of the field in general, but pertinent in the case of the Salvation Army as highlighted below.

[13] Bangladesh did do a cost benefit analysis, and during the period of the evaluation, Zambia undertook the first of a series of strategic planning meetings.

[14]The Salvation Army International provides limited funds to partially cover the running costs of the Territorial Headquarters—for instance in Bandung, Dhaka and Lusaka—but no unrestricted funds for projects. An International Self Denial Fund, replenished from the proceeds of Salvation Army sale of donated goods, is available on a competitive basis to the 57 territories. There is, at present, a freeze on this fund because it is in debt. In addition, there is a Project Fund, which is most readily available for infrastructure projects.

Sustainability appears to be a latecomer to the Salvation Army agenda. In their enthusiasm to shift the locus of control and responsibility for health prevention and care to communities, the Indonesian and Zambian programs may be unrealistically optimistic about sustainability, capacity and ownership. Echoing a similar phrase in the Indonesia section of the DIP, the Zambia section states: "As the skills of the community trained volunteers increase, the need for the Chickankata outreach team to provide direct services in the field will decrease". While the Zambia team may have reasons to believe that communities can take some responsibility for health care based on their successes in home based AIDS counseling and care, it is unlikely—and probably undesirable—to expect that communities will ever be able to assume the role of professionally trained health providers. This issue was flagged in 1996 internal evaluation which notes that "Conceptualizing the process as a long-term partnership of health workers and communities may be closer to the reality of community capacity building than is that of a near completely self-reliant community capable to address the myriad of health problems with all of their complexity." In Zambia and Bangladesh, an on-going dialogue within the project on the nature of the Salvation Army-community partnership is also evidence of an attempt to achieve a balance between dependency, quality and sustainability.

6.1 Cost Recovery

The Matching Grant has witnessed fee rises, often from free services to token payments. In most clinics, Salvation Army fees are on par with or below what the government charges and well below private providers. Needless to say, because of their relative cost, quality and reliability, Salvation Army services have been popular with consumers, and villagers do remark on the change. Other factors have helped consumers adjust to fee hikes: concomitant fee rises in other health services in Jessore town in Bangladesh; the dearth of alternatives in the Chickankata cathchment and remote sites in Central Sulawesi. Patient numbers have not dropped off in the wake of price hikes. In fact, the Salvation Army clinic in Jessore reports an increase in the numbers of women coming for deliveries, despite the doubling of fees over the last few years from Tka70 to Tka150 (U.S.$1.40-3.00).

The Jessore health service, the largest Salvation Army project in the country, set itself a 20% cost recovery target over the life of the Matching Grant. In 1999 it reached13%. Nonetheless, with an operating cost of $250,000/year,[15] the program is a long way from self-sufficiency.

Perhaps more than services, increases in charges for medicines put pressures on poor beneficiaries. Medicines represent a significant and recurrent cost of running the health program in all sites. The Matching Grant contributed to these costs in all sites. Salvation Army offices continue to receive some drugs from government. SAWSO recommended to offices in Asia that the types and quantity of drugs on hand be

[15] This includes operating costs for the clinic, and community health and development activities.

reviewed and essentialized. Again, more input from international best practice and technical assistance to country offices in planning this cost center in the context of a broader sustainability plan could have benefited Matching Grant programs. There is no official sliding scale for services or medicines in any of the Salvation Army health facilities visited.

To the extent that the Army's commitment is to the poorest of the poor, there has in the past been a philosophical commitment to free services, something which lingers today. Indonesia's innovative approach to cross-subsidizing rural clinics with revenues from VIP hospital fees satisfies this concern. The Bangladesh office has an informal sliding scale—physicians send patients who they believe can pay to buy medicines on the open market, while poorer patients are given medicines at the clinic.

Cost hikes merit more systematic market research in all three countries, but particularly in the Asian contexts where many consumers have alternatives and are paying for them. This kind of research is essential to a sound sustainability plan.

Two other creative attempts to generate funds at the project and community levels bear comment.

1. In Bangladesh, Matching Grant funds were used to expand the Training center in the Salvation Army offices in Jessore. A good idea in principle, justified also by the fact that it is the only training center in the area where the proximity to a clinic offers the opportunity for experiential learning. But it is by no means the only training center in Jessore, and will require staff time not only in advertising, but also in managing and maintaining it. The jury is still out as to whether this was a sound idea, given current staff resources and the assumptions made about local demand.
2. In Zambia, CPTs, in their role as social action groups, have been encouraged to generate funds to be able to resource community projects such as clinics, bridges, and schools.[16] While these are valid and viable objectives, the income-generating venture may not be the optimal first activity of a community group. The potential for failure, based on a lack of expertise, mismanagement of resources, attrition, and conflict is high, and may put the whole CPT venture at risk. Indeed, in one community where the CPT has established a fish farm to fund its orphans' program, such issues are emerging.[17] A community committee is not a small enterprise group. Resources should be generated through other, more appropriate mechanisms.

[16] In an attempt to secure greater financial autonomy, NGOs in many settings, have launched business endeavors, which sometimes have little to do with their core mission. In some cases, typically when the NGO is large and established enough, such businesses thrive and do provide an unrestricted income stream to the agency. But this is more often not the case.

[17] On the other hand, a CPT which—with the help of the Salvation Army--secured a grant from a foreign embassy to build a clinic seems more able to manage.

6.2 Insurance Schemes

The Salvation Army in Zambia has taken some interesting steps towards the development of an insurance scheme that has the potential to raise significant revenues. The scheme, which offers consumers several coverage options at the Chickankata hospital and allied clinics, involves annual payment in-kind for participants over the age of 5 (under 5's are free if parents participate). The nature and amount of the payment[18] was negotiated with communities via the Council of Headmen which has become a *de facto* advisory committee for the project. Because of the social structure of communities in Zambia, and in part because CPTs exist in many target communities, this proved an effective conduit for communicating and receiving feedback about the scheme. It allowed broad-based discussion to take place before details were finalized. The fact that hospital fees were being increased at the same time as the insurance scheme was introduced, added an incentive to join. At the time of the evaluation (which coincided with the post-harvest season), grain was being collected and initial enrollment results looked promising. Although the scheme has taken the 3 years of the Matching Grant to get off the ground, the foundation has been set for a pilot with huge potential.

Although the DIP and annual reports suggest that an insurance pilot was planned and implemented briefly in Indonesia, the evaluation found no evidence of it in any of the communities visited, and staff seemed unaware of this activity. On the other hand, the evaluation discovered a mini-insurance scheme which, although originally a government program, appeared to have gained support and momentum from the project. Volunteers in current and non-current communities are collecting fees from mothers participating in the *posyandu* to cover costs associated with the monthly baby-weighing sessions which also include feeding for malnourished children, immunizations and basic medicines. According to the volunteers interviewed in two such villages, all mothers participated in the scheme. Fees range from Rp 250-500/month (US$0.03-0.06). Mothers who were unable to pay, were still allowed to participate and defer payment until the next month.

This serendipitous finding points favorably to the sustainability of the volunteer program. It also raises questions about the design of the original insurance scheme—what lessons could have been transferred from one to the other? Two points are noteworthy in this regard:

1) According to the provincial government, there is a renewed government interest in revitalizing the *posyandu* system—in Central Sulawesi under an ADB loan currently in the pipeline. The *posyandu*-linked insurance scheme suggests an opportunity for documentation with an eye to recommendations on replication and scaling up.
2) At the moment, the government has instituted a safety-net system covering the very poor during the economic crisis. When this scheme ends, as is expected in the next 12 months, what then?

[18] Originally the Salvation Army proposed a combination of cash and grain.

Finding an operational model for health insurance for the poor is a real challenge. The Salvation Army has two potentially viable models. Country offices should be encouraged to document the process and results.

7. STRUCTURAL ISSUES

This section examines structural, strategic and philosophical linkages within the health program, at the country and Territorial Command level of the Salvation Army, and between the Salvation Army and other agencies, notably government and other NGOs. The role of SAWSO in this nexus will be taken up in the next chapter.

7.1 The Hospital, the Clinic, and the Community: Staffing and Structures

Most Salvation Army programs started with a hospital, which remains the administrative and programmatic focal point for health-related activities in each country today. The transition to community outreach requires organizational adjustments in fiscal and human resource allocation, and the locus and nature of decision-making authority. Community outreach structures, which will never be financially self-sufficient, remain more or less vulnerable, with most of their staff on loan from Salvation Army hospitals or clinics. Although structures vary somewhat across the three countries visited, in all cases loose ends remain to achieving the full integration of the community outreach program into the health delivery system. There appears to be a continuum in the three countries: there is no organogram for the health program at all in one country, a disputed one in another, and one that has seen multiple revisions over the last 6 years in the third.

To the extent that key mangers in each country were more or less risk averse, the Matching Grant and other donor resources have allowed the Salvation Army to add expertise by providing funding for salaries, staff training[19] and training for volunteers to enhance the outreach program and in important ways ensure its sustainability.

The Indonesia program is by far the most vulnerable. Despite six years of Matching Grant support to the community outreach program, formal, horizontal reporting and administrative lines of responsibility between the hospital, rural clinics, and community programs remain undefined. The community outreach program has functioned primarily on the basis of informal cooperation among these structures. To make matters worse, key health personnel have been withdrawn from the program over the last two years, leaving it currently with only one junior nurse; other senior staff have limited public health expertise. The sudden death of the lead trainer two yeas ago left a huge hole in the project's expertise—one that project staff elected not to fill, preferring to make do from their own resources.[20] The skeleton team, with neither a vision for itself nor established structural links to the financial and institutional core of the Salvation Army health services in Palu, and with no other sources of external funding, may retreat back

[19] In Indonesia and Bangladesh, Matching Grant funds were used to train individual staff in agriculture and development management respectively.

[20] By all accounts this individual brought dynamism, energy and skills to the team, which were never, in fact, replaced by the others. SAWSO viewed the decision making process as largely beyond their domain, and views the outcome as an empowered team.

into the hospital from whence they were seconded. The project, having run its course, may too. This situation is ironic, given the interest and vision of the Palu hospital Director in making the Palu hospital a "hospital without walls". Without strong organizational links between the hospital, rural clinics and the community outreach program, opportunities for this to happen have been missed.[21]

The situation in Indonesia raises questions about the commitment of the THQ, which makes key staffing and all structural decisions, to the community aspect of the program. Located on another island, it is difficult to know exactly what the THQ's understanding of the local situation and what their vision for the future of the community outreach program is.[22] The DIP anticipates a training for the THQ in community health. Unfortunately, this never eventuated. Neither did the adaptation of lessons learned from the Sulawesi community health project to the Java context—also anticipated in the DIP. Two strategic opportunities missed.

While this is perhaps an extreme case, it does raise issues about structural integration, the relationship between medical services, community health programs and the responsible THQ, as well as programmatic integration—all issues which bear on the International partnership. The discussions that follow are informed only by impressions from the three countries and SAWSO.

7.2 Integration

In addition to integrating the community outreach program into the health delivery system, all three countries have taken steps to integrate other development activities into the health outreach program. In Indonesia, this involved the addition of an agricultural extension professional, who operates as part of the mobile team.

Similarly, in Zambia--largely because of the pre-eminence of the hospital in the catchment area--staff engaged in income generation and agroforestry have been integrated into the community health program, which has been renamed the "Community Health and Development Department", reporting to the Director of Health Services.[23] What is anomalous in the structure of the program is the number of discrete focus areas for the mobile team with their respective professional staff and volunteer health workers. At the present time, there are six types in all. The SAWSO Representative, Bram Bailey, lived at Chickankata in the early 1990s. He explains:

[21] The Director was not actively engaged in the Evaluation—except in one Government meeting. Although the hospital provided trainers and referral services to the project, the Director appears to have been a marginal player in project visioning and implementation.
[22] The consultant did not meet any THQ representatives in Indonesia.
[23] There are three Units under the Community Health an Development Departments: 1) Health Promotion; 2) Community Development; and 3) Community Based Support which is entirely devoted to dealing with AIDS including home based care and counseling and an orphans' program.

> The outreach program began in the late 70s - early 80s as an extension of the services being offered at the hospital. During those early years the outreach program consisted of the mobile clinic going out and doing immunizations and the setting up and maintaining of four rural health centers. This led to the training of community health workers in the mid 80s. Chickankata outreach program predates the government's push to establish community based health programs. In the mid 80s, Chickankata was already quite a complex health facility with many departments: Maternal/Child Health, Leprosy/TB, Nutrition, Primary Health Care and HIV/AIDS. As the vision for working in the community developed, each department saw the need to also work in the community and to train their own volunteers. This is how we ended up with such a diverse group of trained volunteers. It was a very vertical structure with each department having its own domain and often ended up with three to four teams from Chickankata visiting one community in a month, each with its own separate agenda. This is how the program functioned until the Matching Grant, which focused on bringing these different departments together into a coordinated outreach program. (Email correspondence, August 2000)

The process of integration in Zambia is a dynamic work in progress with the organogram undergoing consistent consideration and revision and recent changes at the Manager level. Among the volunteer cadre, natural attrition is compounded by attrition from death in the catchment area where 20% of the population is HIV positive. Nonetheless, project staff realize that the maintenance of this number and diversity of staff and volunteers may be too expensive and unnecessary in the longer term.

Bangladesh offers different lessons on structure and integration. The health program in Jessore is the Salvation Army's largest in country, but the Salvation Army only runs a clinic, as there are a number of major hospitals in the town. Women's literacy and credit programs were run parallel to health activities in the past. Over the last few years, bridges have been built between community health and these other development initiatives, though to date integration has meant primarily a more open dialogue. In the long term, the vision is for community workers to have a rudimentary understanding of techniques in all fields. But in Bangladesh, the first hurdle to real integration is at the senior management level where program integration has led to a debate on whether it continues to make sense for the senior medical director—who is responsible for all of the health programs in the country--to lead the project. The Matching Grant trained a development administrator—based full time in Jessore--for this position. This tension between technical, management, and geographic considerations plagues nearly every institution with multi-sectoral and multi-site programs. It is likely to arise in other parts of the Salvation Army world—if it hasn't already—as programs diversify. As the staff in the

field seek to resolve this with their commanding THQ in Dhaka, they may be setting precedents, which other country offices could benefit from.

While there are no "right answers", institutional blueprints, or guidelines from the Salvation Army International Headquarters, the issues in each country are current, dynamic and analogous. Dialogue among the participating countries would help to validate, motivate and enrich this important aspect of institutional transformation. As in other aspects of the program, SAWSO has provided an outside "ear" and on-going moral support to these changes, but enabled no cross-country dialogue. Perhaps overly passive in the case of Indonesia, the Salvation Army/Zambia credits SAWSO with providing input and technical assistance which was instrumental in the conceptualization of both the outreach and integration initiatives.

7.3 Development in the Context of the Salvation Army's Structure and Mission[24]

The Salvation Army mirrors many international NGOs in its structure, in that it is, today, a confederation of more or less financially independent offices—Territorial Headquarters in this case—linked together by a common mission and institutional structure managed from its International Headquarters in London. The IHQ, under the direction of the Salvation Army General, commands an army of Salvationist officers, who are managed, financed and moved at its behest. IHQ also underwrites much of the overhead and some of the program costs associated with each THQ. The Army officers in each country manage a corps of Salvationists at the grassroots—church members living in their own communities, responsible for evangelism and community work (though in most cases not directly involved with the externally-funded development programs of the Army). What makes the Salvation Army unique is the extent to which local THQs set their own policy and define their own programs, with considerable autonomy and lack of central interference. This has enormous bearing on the existing variation in development thinking and practice across countries.

The religious and developmental activities are closely interlinked in the mission of the Salvation Army. In the past, (usually expatriate) Army officers directed the hospitals and schools run by the Salvation Army. By establishing significant infrastructure and placing staff in these communities, the Army made a commitment to remain indefinitely. The trend towards indigenous management[25] and more developmental programming has brought with it a cadre of non-Salvationist development professionals to lead and staff many of the Army's development programs. These professionals report to the senior Army officer at the site or THQ. These changes have served in some senses to de-link the spiritual and programmatic strands of the Salvation Army. This has happened on two levels: in terms of staffing and structure, and in terms of relationships with communities. Today, development professionals who are usually not members of

[24] These comments necessarily reflect very limited exposure to the Salvation Army and should be read as impressions.

[25] In general, either the Territorial Commander or the head of Finance or both are expatriates in most THQs.

the Salvationist church or Army, are tasked with managing and implementing Salvation Army programs. They report to Army officers who have little or no background in the specific technical area they are managing, or development in general. These officers have financial and managerial authority over programs and senior staff. The level of interest and involvement appears to vary from place to place, depending on the interest of the THQ and the investment risk it has in development activities. Army officers are transferred with some regularity as well, so that the nature and level of this authority may fluctuate. Compounding this, the Salvation Army has no established system for performance appraisal of non-Army staff internationally, and none existed at the country level in any of the countries visited—a factor of understandable concern to local staff.

The Salvation Army's commitment to remain in communities long term, provides a unique context for community partnership. In the past, this partnership was based primarily on an importation of services and beliefs. Today, as local Salvation Army offices assume greater legal, fiscal and decision making autonomy, and become more fully indigenized, professional staff have initiated a dialogue with communities that has more to do with equity and less with dependency or evangelism. The extent to which Salvation Army offices have genuinely engaged in this process is commendable, particularly given historical community expectations of indefinitely available free and fixed facilities. This engagement has certainly strengthened the development message and impact. Certainly the Matching Grant helped to deepen this dialogue.

Development activities that seek to achieve local ownership in the name of sustainability have and will continue to require the Army to redefine their profile and relationship with communities. The question arises as to whether this challenges or even contradicts its pastoral profile. There is language in the proposal and the DIP about complimentarity of these structures—about mobilizing Salvation Army cadres. But this type of integration appears relatively superficial, and in most cases projects rely on their own, interdenominational staff and volunteer cadre to operationalize project objectives.

It is to the Salvation Army's credit that it has not imposed religious criteria on the selection or performance of project staff or volunteers. On the other hand, the Army structure offers its own unique set of challenges for achieving development ends, in part because of this openness.

7.4 Relations with NGOs

Although as an organization, the Salvation Army identifies with other Christian agencies, it does not appear to seek alliances with any of these organizations regionally or globally. The pattern and nature of its local linkages varies across countries. In various countries, the Salvation Army has been a recipient of training and to a lesser extent technical and financial assistance from local and international NGOs.

Bangladesh has used local NGO expertise for staff training—for instance on arsenic detection[26], gender and legal rights. The Indonesia office sent several staff for community and health-related training to NGO centers in North Sulawesi and Java. Salvation Army representatives meet with other NGO representatives in NGO/GO meetings.

The Chickankata center trains NGO and government professionals from all over Africa on HIV/AIDs prevention and community and home care, as well as other development-related topics. Possibly because of this regional training center, the Salvation Army at Chickankata in Zambia is anomalous in Salvation Army world in the relatively high profile role it plays in the NGO community in Zambia. The Director of Health Services at Chickankata Hospital was recently elected the Chair of the Christian Medical Association of Zambia (CMAZ), a powerful consortium of NGOs empowered to deliver a portion of health services on behalf of the Government of Zambia.

As an agency, however, the Salvation Army does not appear to actively seek linkages with other NGOs for technical, information sharing or advocacy purposes. It is not clear whether this is intentional or by default. Either way, it is likely to be as much the result of its evangelical and apolitical mission, as the Army hierarchy itself which provides a built in global network which may preclude a felt need to actively network with other NGOs. This historically inward-looking organizational culture can be expected to change as country offices become completely indigenized and begin to reach out to local NGOs in their own countries for information, skills and technical assistance sharing. It can also be anticipated, based on intentions to adopt and advance best practice in health sector programming.

SAWSO points to its membership in the Child Survival CORE NGO group as an important factor in its ability to access best practice information and training for staff. SAWSO has also provided an HIV/AIDS training for the NGO Networks Project.

7.5 Relations with Government

As discussed above, the Salvation Army has long-standing, well-established and very positive relationships with governments in all of the countries reviewed by this evaluation. Governments express appreciation and respect for the high quality medical services the Salvation Army has provided over decades, its commitment to communities not reached by government services, its commitment to addressing diseases that government is unable to tackle effectively[27], and its efficiency in reporting. In return, as mentioned already, government provides medicines, immunization and cooperates in

[26] Arsenic has been found in the groundwater in many parts of Bangladesh, presenting a formidable public health challenge.

[27] District Government officers in Bangladesh noted the significant contribution of the Salvation Army in the detection and treatment of leprosy and TB in the Jessore area; statistics indicate a much higher detection and cure rate for the Salvation Army than Government. The Salvation Army's Chickankata HIV/AIDS program is considered a model in Africa.

basic public health activities. This kind of cooperation is enabled by the fact that Salvation Army programs typically follow government protocols and design.

To the extent that the Salvation Army has the respect and "ear" of the government, it does relatively little to actively leverage its position in favor of program innovations it has trialed, or give voice to concerns of the people it serves. Although not conceived as pilots with an eye to scaling up or replication, the Salvation Army is nonetheless learning lessons and improving in many cases on government models. These lessons have remained internal to individual projects as they go undocumented and unshared.

The Salvation Army has begun to make its mark internationally, and continues to innovate in the HIV/AIDS sector. The potentials for wider impact on policy and programs having to do with HIV/AIDS as well as other areas related to community health, some of which have been mentioned in this report, are greater than current achievements. This type of "technical" advocacy would require a shift in mission, as well as a commitment of staff and resources and approach. At this point this does not seem high on the agency's agenda.

8. SAWSO

Much has already been said about SAWSO's role in providing technical, capacity building and other support to Salvation Army partner offices. This chapter will summarize and explore this issue in more depth and, although it was not an objective of the project, explore the ways in which the Matching Grant served to build SAWSO's capacity.

8.1 Technical and Capacity Building Support to Country Offices

In the context of the Salvation Army partnership, SAWSO must be invited into a Territory to support a project or provide technical assistance. As described above, Territories are more likely to respond positively to assistance that fits into on-going programs than, for instance circumscribed, stand-alone initiatives. Because of the nature of the Salvation Army partnership, relationship building is a cornerstone of SAWSO's approach to development activities. SAWSO makes it a point to maintain a respectful attitude towards recommendations and decisions made at the local level[28]. Internationally, SAWSO sees itself as a prime mover in encouraging and providing technical substance to the Army's transition to community outreach in health and other sectors—by advocating at international meetings of the Salvation Army, and through program support such as the Matching Grant.

SAWSO maintains a small office of ten staff, who divide the country backstopping and technical assistance responsibility among them. As described above, the SAWSO Director is an Army Officer, but the program work is managed by a Deputy Director and staff who, except for one, are not members of the church.

Salvation Army partners feel supported and understood by SAWSO, although this has not always been the case. All appreciate the financial support SAWSO has garnered on their behalf. In Bangladesh and Zambia, partners credit SAWSO with helping to advance programmatic outreach and integration respectively, and in particular seeding the concept of community health committees. The KPC survey, introduced by SAWSO, was noted as an empowering and important tool in several partner countries.

And yet, looking back, in light of the task SAWSO set itself, achievements appear to have occurred more by serendipity and less by design, and opportunities, particularly for sharing and synergies, have been missed. Neither integration nor sustainability—key foci of the overseas program—were modeled nor given concerted consideration at SAWSO. Country programs pretty much operated independently of one another. No formal and few informal mechanisms for sharing results, issues, lessons and building networks on this basis exist in the Alexandria office. As a result, some potentially exciting opportunities for cross country sharing—on the MIS, insurance schemes,

[28] This has emerged in part as SAWSO has sought to set itself apart from other Salvation Army "donor" countries who are perceived to be more top-down in their orientation.

gender, volunteer programs, HIV prevention etc.--were missed. A key objective of the project—sustainability—remains an intangible, in part because until very recently staff did not sit together on a regular basis to think through a framework. Neither did SAWSO model the active use of monitoring data to discuss programmatic issues with field offices.

The nature, content and even understanding of the purpose of field visits appears uneven in the organization. Partners seemed to like having SAWSO around, used SAWSO to explore new ideas, help prepare donor reports, and even at times intervene on their behalf with THQ. But SAWSO direct, technical assistance, training, or government or NGO networking appears limited. There are NGOs engaged in cutting edge programming on the issues Salvation Army is struggling with in all three countries, as well a significant literature on the issues. Other PVOs are connected into these networks, and their recommendations could have opened doors for the Salvation Army partners to begin to network as well. Overall, with the exception of Salvation Army/Zambia, the Salvation Army in Indonesia, Bangladesh and the U.S. have only dipped a toe into these communities or literatures. In only one case did anyone note that a technical manual from SAWSO had been given to a partner. No reports, articles or the provision of SAWSO-delivered training were mentioned. Only one of the partner agencies has access to the Internet; one does not even have a phone. SAWSO could have done more to act as a screen and conduit for information and to help identify issues and local consultants for technical assistance and training.

Although SAWSO sees itself as an advocate for change within its international partnership, field informants made more frequent mention of a representative from IHQ who has used community outreach for HIV prevention and care as a jumping off point for enlarging community participation in Salvation Army programming. This person was credited with introducing new thinking, even with government representatives. This is not to say the potential is not there. SAWSO has the programming experience, the data and the organizational position to be able to move and motivate. At present, although it is supporting from behind, it may not be leading as much as it is capable of doing.

8.2 SAWSO and USAID

SAWSO and USAID appear to have retained reciprocally open and constructive lines of communication through the Child Survival and Matching Grant periods. The proactive interest of previous PVC officers was highly appreciated, particularly as this led to greater engagement with the wider PVO community. SAWSO also appreciated the process of proposal, DIP and report writing as a discipline for organizing information in a formal way, though certain forms felt repetitive.

Salvation Army offices have maintained a relatively low profile with USAID in the field, particularly in Asia. USAID in Zambia, on the other hand, regards the Chickankata program as a model for HIV/AIDS prevention and care.

8.3 Financial Management

This review did not address itself to matters related to financial management, as both parties agreed this to be unnecessary given SAWSO's excellent record in this regard. The question of whether Matching Grant funds helped SAWSO leverage additional monies, raised in the SOW, was not discussed directly with SAWSO. This does not appear to have been the case however. The Matching Grant did allow programs to continue, but whether it helped establish the case for additional funding is less clear.

9. RECOMMENDATIONS

Country-specific recommendations are included in the debriefing notes in Appendix B, and have been shared and discussed with staff in each country (including SAWSO). Some highlights and overarching recommendations are listed here, with the understanding that SAWSO has another three years of Matching Grant assistance, an agreement to continue funding in Bangladesh for another year, and several options vis-à-vis Indonesia. They also consider SAWSO's future strategic and technical role in the Salvation Army International and the PVO community in the U.S.

9.1 SAWSO/Overall Recommendations

a. SAWSO should develop a 5-10 year Strategic Plan, which identifies key strategic goals and themes and considers the activities, resources, timeframes and outputs. This would help link projects and country programs and encourage greater synergies and learning on cross-cutting issues;
b. SAWSO should place more resources and attention on documentation of key aspects of its program with an eye to sharing experience and learning across countries, advocacy with in the Salvation Army, as well as with donors and governments;
c. In line with this, country offices should be encouraged and supported to document experiments and interesting activities;
d. SAWSO should be more pro-active in identifying needs and resources for technical assistance and training;
e. Tools (including software) for key program areas like MIS, training, supervising volunteer programs, sustainability and cost/benefit analysis, quality of care etc. should be researched, distributed or developed;
f. In partnership with local project staff, SAWSO should consider taking a more pro-active role in raising and discussing specific project-related and broader development-related concerns and issues with THQs and governments;
g. Gender analysis needs to be undertaken for all existing and pipeline programs and training and assistance to country offices made available;
h. Carefully organized cross-visits between Matching Grant and other Salvation Army partner agencies should be encouraged to facilitate dialogue on programmatic and organizational issues;
i. In light of its past intervention in Human Resource Development, SAWSO may wish to consider providing assistance to the Salvation Army International Partnership is performance appraisal.

A summary of country-specific recommendations, which are detailed in Appendix B follow.

9.2. Bangladesh

a. Seek resolution on the management structure of the project;
b. Advocate for the program within the Salvation Army system;
c. Develop a long term program, fundraising and sustainability plan which is not totally dependent on external donors;
d. Maximize local revenues: fees, Salvation Army, government in-kind or contracting, training center rental;
e. Consolidate integration efforts;
f. Improve gender as a priority related to how the program impacts on women's control over resources and decision-making. Model commitment to gender in staff hiring.
g. Use existing clinic and project data more effectively for management and advocacy purposes;
h. Use data to make the case for doorstep programming and VHW impact;
i. Do a study on the cost effectiveness of village health workers.
j. Train village health workers to understand, manage and share data effectively.

9.3. Indonesia

a. Revisit and realign current anomalies in the institutional relationships in Palu—hospital, clinic and community program to maximize support to the latter;
b. Develop a list of technical assistance needs to include but not be limited to: kadar review, supervision procedures for village health workers, community and project-based MIS;
c. Address the issue of recurrent costs for medicines by drawing on lessons learned from the posyandu insurance scheme system;
d. Educate the THQ on community health programming;
e. Share learning's with government; explore greater financial support.

9.4 Zambia

a. SAWSO should provide more TA on MIS development. The MIS system should become a model for other countries;
b. Document the insurance scheme to be able to understand and share learning's;
c. Revisit the number of different type of staff and counterpart volunteer positions to see whether positions can be consolidated to enhance efficiencies;
d. Mandate greater gender balance in CPT's;
e. Continue support to CPT's;
f. Do not encourage CPTs to take loans or operate as microenterprises;
g. Revisit the gender issue when identifying community health volunteers;
h. Model gender equity in hiring.

Appendix A

Scope of Work

SCOPE OF WORK
FINAL EVALUATION
SALVATION ARMY WORLD SERVICE OFFICE (SAWSO)
MATCHING GRANT FAO-A-00-97-00049-00

PROGRAM IDENTIFICATION
PVO: Salvation Army World Service Office (SAWSO)
Cooperative Agreement with USAID/Washington, Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation, Matching Grants Division No. FAO-A-00-97-00049-00
Activity Dates: 09/97 – 09/00
Countries: Bangladesh, Ghana, Indonesia, Zambia and U.S. Headquarters in Alexandria, VA

PROGRAM BACKGROUND
History: SAWSO was awarded a $900,000 matching grant on September 1997 over a period of three years.
Program goal and purpose: Through this project SAWSO aims to 1) improve the health status of women and children in target communities, 2) increase the capacity of local non-government organizations to develop, implement, monitor and evaluate sustainable community-based health programs; and 3) build on basic health information system put in place by SAWSO over the last 2 1/2 years and ensure that the system remains operational and sustainable after the project ends. These objectives will be accomplished by 1) training community members and health staff; 2) developing and applying community-based approaches to existing community health programs; 3) providing local and international technical assistance to country programs in monitoring and evaluation, health information, management services, training, community mobilization, and program and financial sustainability strategies; and 4) documenting community-based approaches and sharing these with other development partners. (See Appendix A for the Planning Matrix)

Current implementation status: This is a three-year project and is currently at the end of its third year. As reported in the second annual report in November 1999, health specific indicators are on target midway through the grant. Sustainability and capacity building components generally meet objectives proposed for the grant and vary from country to country.
Partners: Salvation Army/Bangladesh, Salvation Army/Ghana, Salvation Army/Indonesia, and Salvation Army/Zambia are indigenous NGOs. The purpose of the grant is to increase their capacity to develop, implement, monitor and evaluate sustainable community health programs.

Availability of Data
Data reported from the following sources will be made available to the evaluating team:

3. First annual report (submitted on November 1998); second annual report (submitted on November 1999)
4. External midterm evaluation report (Zambia and Indonesia, 1996); internal midterm evaluation reports (Ghana and Bangladesh, 1996)
5. Data generated through SAWSO's monitoring and evaluation system

PURPOSE OF THE EVALUATION

USAID: This final evaluation fulfills the requirements of the USAID/BHR/PVC Matching Grant Program. PVC will use this information in its annual Results Report, the review of any follow-on proposals and in distilling "lessons learned" for broader application.
SAWSO: Results of the evaluation will be used to prioritize future technical assistance needs of NGO partners. The evaluation will provide feedback on strengths and weaknesses related to SAWSO's role in implementation.
Local NGOs: The evaluation process and results will provide NGO partners with guidance in their future decision-making and continued organizational development and implementation of community health programs. It is expected that NGOs will further benefit from SAWSO's technical assistance, following the evaluation, as identified areas of weakness among SAWSO and NGOs will be targeted for improvement.

EVALUATOR STATEMENT OF WORK

The evaluation team, led by the consultant, will assess the following program and institutional elements, providing evidence, criteria for judgment and citing data sources. The team will assess both headquarters and the country level programs in Bangladesh, Indonesia and Zambia. An estimate of the percent emphasis or level of effort for each segment of the SOW is in italicized brackets (to be determined)

Program Implementation

1. Assess progress towards each major objective:

- Based on the program planning matrix, or statement of program purpose from the proposal, have the objectives been met?
- Identify constraints encountered and assess SAWSO's response to them. PVC is particularly interested in how SAWSO used monitoring & evaluation information or special studies, operations research, etc., for decision-making.
- Identify major successes and why these elements were successful.
- Assess effectiveness of models, approaches or assumptions that underlie the program. Comment on the possibility or plans to scale-up the approach

2. **Assess the impact on the local partners (NGOs, local government, CDOs) in the implementation of the Matching Grant; assess satisfaction of project beneficiaries with project activities.**

- What were the organizational benefits of implementing the Matching Grant?

- What organizational and technical skills were built or changed in the local partners. (*consider new skills acquired, new systems and procedures established, quality of relationships with communities, improved program ability to met needs of beneficiaries, other team building aspects, etc*.)

- What were the organizational challenges in implementing the Matching Grant?

- How did the Matching Grant activity or service in which you participated affect your life? Your community? (*to be asked of community leaders, community health committee members, and community members*)

3. Assess progress towards sustainability

- Identify the program elements to be sustained; the sustainability objectives and indicators; the achievements to date; and the prospects for post-grant sustainability.

- b) Describe the existence and status of cost-recovery mechanisms, local level financing or other approaches to generate resources to support project operations.

4. Assess the status of strategic_partnership(s) with NGOs, community-based organizations or local level government

Characterize "partnerships" with local level partners

- Roles, responsibilities (decision-making power)
- Mechanisms employed (MOU, sub-grant, contract, etc.)
- Fiscal autonomy and amount of grant funds directly managed in past year

How did the program plan to assess the quality and scope of partner relations?

- What was the impact of the partnership on the program?
- What change in capacity of local level partner was planned? What was achieved? What are the effects of training or resource transfer on the capacity of local partners?

Assess the local level partners satisfaction with the partnership

- Has the interface and communications among PVO headquarter and partners been effective?
- Cite the major implementation lessons learned and recommendations

Program Management

5. Assess change in the PVO's management capacity (structure and quality of management) as a result of grant.

Strategic Approach and Program Planning. What changes have occurred in the organization's capacity for critical and analytic thinking regarding program design and impact? Evidence that program has:

- fostered analysis and self evaluation in country programs, or conducted quantitative or qualitative analysis to refine interventions
- conducted periodic review of performance data by project personnel and taken actions as a result of review
- Institutionalized performance monitoring and impact evaluation systems into other non-PVC grant funded programs
- acted on recommendations from midterm evaluation
- Are there changes in the capacity of the headquarters to:
    - manage the planning process: program renewal, strategy integration, project design
    - address over-arching program issues of replicability, scale-up, sustainability, forecasting and strategic planning
    - organizational development, financial planning and development

    - (d) forecasting and strategic planning

6. Monitoring and Evaluation Assess the capacity of the organization to monitor program performance and measure impact. Is there evidence of:

- **a**ppropriate intervention specific; capacity building and sustainability objectives and indicators
- developed baseline assessment and plans for final assessment
- knowledge of and use of impact and performance measurement techniques
- using a management information system (MIS) to consolidate, analyze and interpret project data
- transfer of skills and capacity to local partners

7. Financial Management

- Were adequate financial monitoring systems in place to verify program, revenue, operating and financial expense, other inputs and outputs?
- Has the program leveraged additional resources (beyond the match)?
- Is there an estimate of cost effectiveness of the program?

8. Information

- Comment on the utility and timeliness of PVOs required reports
- Comment on the organizations' (headquarters) public outreach activities
- Logistics: Comment on the adequacy and timeliness of PVOs material inputs.
- Supervision: Assess if there were sufficient staff with the appropriate technical and management skills to oversee program activity at both headquarters and in the field programs
- Human Resource Development: Did the PVO assess and address staff training needs and strengthen the organization and local partner professional or technical capacity?
- Cite the major lessons learned and management recommendations

EVALUATION METHODS

Evaluation approach, appropriate methodology, instruments and tools are to be determined with evaluator.

Approach

Conduct a Team Planning Meeting (TPM) to:

- refine and consolidate the purpose level objectives and outputs into a set of results-oriented objectives
- agree upon a set of appropriate indicators against which the evaluation will assess achievement of project results

Methodology:

The evaluator will:

- determine data collection approaches and instruments to be used
- document data sources, and
- provide a copy (electronic or paper) of all primary data collected and analysis performed

TEAM COMPOSITION AND PARTICIPATION

Team Composition

- Team Leader: a specialist in population, family and international health, NGO capacity building, and community development
- 2 SAWSO staff members at HQ. In-country project directors and project staff will participate in evaluation, as appropriate.

Participation:

- The evaluation team will consist of a leader (the consultant) and SAWSO HQ staff members. Other participants, primarily as part of the team-planning meeting, are: the USAID/BHR/PVC/Matching Grant backstop, PVC's results specialist, and AMATECH evaluation support staff. SAWSO and Matching Grant field staff and NGO partners will be involved in discussions during an evaluation de-briefing

(in each country) and will facilitate site visits. Translators will be provided to evaluation team members in each country (as necessary). Primary responsibility for the data analysis and the final report rests with the team leader. Other team members will facilitate the data collection process, be a source of information. The final report will be provided to AMATECH for distribution and feedback from the PVO and PVC.

- The consultant will lead the team in assessing the level of progress made by SAWSO and NGO partners in achieving results and will closely examine determinants of relative progress in each country. Progress toward objectives will be gauged according to expected achievement of selected indicators and benchmarks set by each country.

Roles and responsibilities of the Team Leader (consultant):

- Review all project documents (to be provided by SAWSO and USAID) prior to site visits.
- Collaborate with the evaluation team in preparing evaluation methodology and instruments.
- Participate in Matching Grant Project de-brief and final planning session prior to evaluation.
- Conduct interviews and focus group discussions and facilitate discussions and other assessment activities among selected stakeholders.
- Lead follow-up discussions among evaluation team and Matching Grant Project staff.
- Draft evaluation results and recommendations and present to evaluation team and Matching Grant Project staff.
- Produce evaluation report as per USAID/BHR/PVC guidelines.
  - Incorporate comments from PVC and SAWSO.
  - Submit report by deadline.

TENTATIVE SCHEDULE

The evaluation will be conducted during the months of June and July following an evaluation team-planning meeting in late May. Weekly evaluation activities (including travel) will be planned as follows: (See Appendix B for the travel schedule to the country sites)

Team Planning Meeting at SAWSO headquarters in Alexandria (3 days)

- Team planning/team briefing
- Orientation and logistics
- Evaluation methods and tools refinement

Week 1: Assessment of Project in Indonesia (6 days)

1. Conduct evaluation as planned
2. Debrief country staff on evaluation findings

Week 2: Assessment of Project in Bangladesh (6 days)

1. Conduct evaluation as planned
2. Debrief country staff on evaluation findings

Week 3: Assessment of Project in Zambia (6 days)

3. Conduct evaluation as planned
4. Debrief country staff on evaluation findings

Week 4: Assessment of SAWSO headquarters in Alexandria (2 days)

5. Assessment of HQ program support functions (administrative and management review; headquarter activities in under the matching grant)
6. Debrief SAWSO staff on evaluation findings
7. Team debrief at headquarters

Week 4 and 5: Prepare Draft Report to submit to AMA Technologies to be distributed to PVC and SAWSO (consultant) (10 days)

Week 6: Report Review by PVC and SAWSO (the consultant is not involved at this time)

Week 7: Final Report Preparation/Submission (consultant) (5 days)

Evaluation leader reviews comments from PVC and SAWSO

Evaluation team leader submits final report to AMA Technologies to be distributed to PVC and SAWSO

REPORTING AND DISSEMINATION REQUIREMENTS

The SOW will serve as the outline of the report

Delivery schedule: final report is submitted as scheduled

USAID/BHR/PVC will review documents as stated

Appendix B

Debrief notes

Indonesia
Bangladesh
Zambia
U.S.A. (SAWSO)

Debrief notes: Indonesia

Debrief notes*
Evaluation of SAWSO-supported Community Health Project, Central Sulawesi

Prepared by: Dr. Laurie Zivetz, Consultant
Palu, July 1, 2000

Intro

1. Thanks for hosting me. Have enjoyed chance to get to know you and to see the project. Thanks to Mr. Topo and Maj. Nopo and all staff, for their assistance and to Maj Nico for his very able translation.
2. This was designed as a joint eval since it was a Matching Grant project, so I don't want to be seen as the only evaluator.
3. You know this project and situation and I have had a few days to observe: so I invite your comments and even disagreements.
4. Sometimes good to have some fresh eyes on a situation. I have designed and implemented many projects in different countries in Asia, so this analysis comes out of my experience and what I know about comm. health practice internationally.

First, I would like to consider: what are the roles NGOs can play in health delivery and prevention? NGOs can:

1. Fill gaps in government services.
2. Pilot new approaches, test new models, with the idea that what works can be scaled up or replicated in the area, region or country.
3. Bring perspectives/voice of those who cannot speak on their own behalf to the attn of those with power over resources, services, and processes.
4. Catalyze local resources to address impt. development issues.

In every situation, there are always resources, possibilities opportunities AND challenges.

So in doing this evaluation, I asked the question:

- Did we meet our objectives?

And also:

- Did we build most effectively on local resources?
- Did we recognize possibilities?
- Did we take all opportunities?:
- How did we respond to challenges?

I would like to consider the role that the Salvation Army in these terms, and with your permission make recommendations for the future based on these roles.

* This is not meant to be an official document, and should not be quoted as such.

Overall:

1. The project met many of its health objectives.
    - Health status and awareness of prevention methods improved. Good marks for that.
    - The grassroots *Kadar* was supported and revitalized.
    - Reached people in remote areas not being reached by government.

2. You did this in the face of significant challenges: staff changes, and enormous political and economic changes not anticipated when the project was designed.

3. Your greatest achievement was filling gaps in government services. You reached remote areas and appear to have put in place or strengthened government programs at the grassroots. While most of the *Kadar*s and programs appear to have been in place before the SAWSO project, the training and supervision provided by the project no doubt encouraged and upgraded both.

4. But did you see new possibilities, build on opportunities, and respond to longer term challenges? In this, performance has been mixed.

5. Also, the extent to which the project has been able to think through and put in place community and Salvation Army based structures for continuing its work after this 6 years of external funding is disappointing.

If I were sitting in your shoes, after all the hard I've done, I would be wondering and probably worried: what will endure from what I've done? what next?

6. I would like now to highlight what I said about missed opportunities and then make recommendations for the future.

THE TEAM

1. In the DIP the team was supposed to be composed of:
    A Project Director
    A Team Coordinator
    3 Nurse Midwives
    3 Field based environmental sanitation workers
    4 Supervisors
    370 *Kadar*s
    75 Midwives (*Dukun Bai*)

Currently:

A project Director and team coordinator neither of whom have community health background
1 Nurse Midwife
1 field based environmental sanitation worker

1 part time agriculturist
187 *Kadar* in active villages (370 including villages where the project was active for the first 4 years)
75 Midwives

The team has many fewer staff than what was anticipated. It is also very short on community health expertise.

TRAINING

1. DIP anticipates annual training for VHWs. Appears it was more like once every two years. Why?

2. DIP also anticipates training village heads and teachers once a year. Did this happen?

3. Training of *Kadar*s is fundamental to the success of the whole project. So expertise of trainers should have been given highest priority. Salvation Army and Government trainers used to deliver training. This is ok. But how much training were they given in participatory methods? How much was information from other sources in training VHWS drawn upon?

4. Its not really fair to expect people with only 2-3 weeks training in the subject to deliver training.

5. The team deserves credit for adapting the government curriculum when it seemed to be too abstract or too boring--not participatory enough. Did you get feedback from participants in a systematic way that could fine tune the training? Did you provide this feedback to government thereby perhaps catalyzing much broader changes?

6. It is a good idea to take the training closer to the *Kadars*. 80 people in one training course is too many. Smaller trainings will be more effective and cheaper--less travel costs, fewer staff and the training can involve local health providers and leaders in some way.

***KADAR* SUPPORT**

1. The *Kadar*s are the foundation of the whole program. Is training enough?: Yes, gives motivation. But supervision is also important.

2. You struggled with the lack of sufficient supervisors throughout the whole project. Perhaps this was an opportunity missed? In Maranatha, we heard from a *Kadar* with 20 years experience that she would enjoy being a supervisor. A cheap and local opportunity!

3. The project seems to have laid a solid foundation: when blue became red, there was still enthusiasm for continuing on. Question: how long will it last without continued support?

4. Did the project look more closely at how much support *Kadar*s really receive from the *puskas mas* and other health institutions? Do you understand how such institutions can BEST support *Kadar*s? Your ideas and observations about this are important. This is the kind of thing NGOs can do to help scale up projects,. Would like to see in report to SAWSO, and recommendations to local Health Dept.

5. The DIP anticipates Community Health Committees. It seems that the project reverted to local leadership structures, which appears appropriate. We need to understand how these leadership structures support *Kadar*s--can they say anything about this, which would help in scaling up, in fine-tuning this approach? Again: would like to see in report to SAWSO but esp. in feedback to Government Health Dept.

6. In Watubula we met one *Kadar* who is distributing family planning pills. Another incentive: perhaps she is making a little income while providing this important service. Give her a bit more training and ensure she is supported by the local health providers and you have a cheap delivery system. Document, share!

MIS

1. A major objective of the project according to the DIP was to improve the ability of the Core Team to make better use of data, and share it at the village level.

2. The DIP also focuses on improving the ability of *Kadar*s to use the data they collect for understanding the health situation in their community, and advocating on behalf of mothers and children for services.

3. Data analysis also gives *Kadar*s feedback on their work: are we being effective in the advice we are giving?

4. Today, *Kadar*s are trained to collect, record and pass data up the line. But it goes out and never comes back. They need to be able to analyze and understand it: to aggregate individual information and make sense of trends.

5. This should be a part of *Kadar* training.

6. It also appears that data has not been used very effectively by the Core Team to analyze or plan activities. Both the KPC (which is more of an in-depth snapshot) as well as monthly and annual data on key health indicators can help the team understand how it is performing (E.g. to pose the question: are our villages doing better than non-project villages?) Appears this has not been done.

SUSTAINABILITY

I would like to talk about this on a community, project and institutional level.

1. This was a key element of the program from the beginning and is addressed in all project documents.

2. But it appears that either it was not well understood, not taken seriously, or both. I am concerned now, that as the project winds down, there is still no plan in place for how the community health program in C. Sulawesi will continue.

Some missed opportunities at the **program level**:

1. Insurance schemes: seems there were already *posyandu*-based schemes in place before the project, which were strengthened by the project. It may be fair to anticipate that as long as the *Kadar*s are working well, that the *posyandu* is perceived to be performing a service, people will continue to participate.

2. Other insurance schemes were anticipated in the project, and reports indicate that they were tried, flourished for a while, and faded. No mention of this in any of the villages we visited. Also, the successful *posyandu* -based insurance schemes could have provided a model for different types of insurance schemes (e.g. for drugs, maternity, adult emergency services?). An opportunity missed?

3. According to the Provincial Government, there is a renewed government interest in the *posyandu* syste4m. Has the Salvation Army promoted its learning and offered its assistance? In some countries, NGOs are contracting with government to deliver services: a sustainability option to be explored?

4. Approximately a third of the local SAWSO budget is for medicines for the 10-13 Salvation Army clinics. Question: what now? Is this sustainable? How?

Institutional level:

1. The vertical structure of the Salvation Army health system in C. Sualwesi doesn't lend itself to sustainability. The clinics, hospital and PKMD all report up rather than cooperating across. This has happened informally, but that's not enough. People change, structures don't.

2. Lack of formal links for cooperation and communication between the clinics, hospital, and project limit the extent to which cross-fertilization of learning, ownership and integration have taken place.

3. I have to question THQ's real commitment to community health given the fact that over time health staff have been pulled from key positions in the project, and some who have left have not been replaced.

REPLICATION

1. The DIP talks about creating a model for other Salvation Army offices making the transition from hospital to community-based programs. An excellent idea, but there is no evidence that documentation was done to understand the process sufficiently to be able to communicate it.

2. The DIP talks about training for THQ on community health. Did this happen?

GOVERNMENT RELATIONS

1. In this project, the Salvation Army was essentially filling in gaps in government. services: reviving a government program and reaching remote areas where the government could not reach.

2. What happens in remote areas now when no support to continue the community health program? Sustainability? Has Salvation Army discussed w/Government?

3. How were learnings from the project shared with government? E.g. innovations in training curriculum, insurance schemes?

4. Provincial Health Dept official made two important points:

- NGOs need to approach government for cooperation--advocate (Salvation Army HAS done this in terms of getting trainers etc, what about longer term?)
- *Kadar*s need constant support and motivation to continue. Will government do this in remote areas? Red areas?

RECOMMENDATIONS

Looking at the situation: you have some assets and some opportunities. But your time is running out, at least with SAWSO. To keep what you have gained alive, and make further strides, you are going to have to look at all of the opportunities and move quickly.

My suggestion:

You jointly put together a sustainability plan, which looks at your program first from an institutional point of view:

1. What core skills and expertise do you need to be able to run a community health program into the future? You cannot continue to run this program without more expertise in community outreach on your team. Where will you get it?

2. What institutional structure do you need to be able to support a community health program in the future? The current reporting mechanism which keeps the hospital, clinics and project separate by reporting to THQ without formal lines of cooperation between these entities is unworkable, unsustainable and unadvisable.

Once you do that and it is agreed on both sides, I would recommend to SAWSO that they support a one-year package of Technical Assistance to include:

1. *Kadar* curriculum review, including content, methodology.

2. A supervision plan which includes a look at promoting local women *Kadar*s into supervision positions AND developing procedures for monitoring *Kadar* performance which supervisors can use.

3. Revisiting the MIS system and designing an approach for information use at community level and for Salvation Army staff involved in community health.

I will recommend that this TA package be:

1. Provided by an Indonesian Community Health NGO with whom the Salvation Army can develop a long-term relationship.

2. Be long term in nature, but composed of intermittent, short-term inputs.

3. Be results-oriented: the TA will proceed if the implementing team is able to demonstrate progress on targets that all parties agree upon at the outset.

4. Include a cost-share on the part of the THQ, which might be staff salaries.

Before additional external assistance is provided, I would recommend that the Salvation Army in C. Sulawesi develop a 5-10 year community health outreach plan.

Would invite discussion and questions.

Debrief notes: Bangladesh

Debrief for Salvation army/Jessore, Bangladesh, July 12, 2000

Management Team

Overall:

1. Thank you for hospitality and honesty. Know they are busy and this is taking a lot of time.
2. Your frustration is too much time, mine is not enough. Compromise.
3. Hope my comments will be helpful. Welcome feedback: this is a joint evaluation.
4. Did well: met their health objectives.
5. Seem to be running a sound program: staff empowered, committed management good.
6. Relations w/govt. good.
7. In fact reaching more people than they anticipated. And more than they are getting credit for.
8. Want to touch on some of the key issues here: some are institutional, some programmatic.

Issues:

Project management/ownership

Who owns this project? Who are the stakeholders? Who makes decisions and how?

Org. level:

1. Have made the transition to local ownership @ the program level well--management team seems to be in charge and confident. You still need to work out some of the internal management and reporting aspects of the program, and the sooner you and the authorities do this, the better.

2. However, even when this is accomplished, you don't feel completely in the driver's seat because some major decisions made outside of the project, which directly impact on how the project is supported and run, and esp. its long term.

3. You are working in an org. Structure that may not share exactly the same development perspective as you do. This is not likely to change quickly, and perhaps not completely even in the longer term. It is part of the org. culture in which you will continue to operate.

4. The good news is that your development program is essential for meeting some of the central objectives of the org., even if the empowerment approach you have chosen may be slightly at odds. You must be able to leverage this.

5. Now you are trying to implement a more participatory approach at the village level: to give ownership to communities via the CSG approach.
   - ♦ Do the "authorities" understand this enough to support it?
   - ♦ Raises issue: Does it compliment Salvation Army overall agenda?

- Is this possible?
- Is the approach sustainable for instance if the development aspect of the program withdraws, but the ministering aspect remains?

Key issues to consider.

6. In some ways, the project is also owned by the donors: because of dependence on external funding.
   - How can you comply with different donor mandates re. approach and reporting? The challenge has been to make projects fit into what is an evolving program. I can see that what looks like a project with a beginning a middle and an end on paper for USAID is in reality a piece of a larger and longer process and program. That is fine. It is good. But it is not the way the donor world works, as you well know.
   - Creates tensions w/in the project in terms of design, competing donor demands, and demands on project/admin time.

Recommendations:

1. Seek resolution on the new management structure ASAP.
2. Re your program's relationship with the Salvation Army: Your challenge now as a team: find your allies, focus on the important issues and don't stop talking a bout them, manage up, engage and educate your superiors.
   - Why is it important to engage with villagers?
   - What does sustainability mean to communities and to the Salvation Army as a whole in terms of resources, community commitment, results, impacts?
   - Ask for information, engage in fundraising.
3. A long-term plan is essential.
   - This should include a clear staffing plan and organogram which reflect the objectives of the plan, targets which are programmatic and financial, and a fundraising agenda.
   - It should clarify roles and responsibilities re programmatic, funding, staffing, budgeting and management responsibilities.
   - I recommend that this planning be undertaken as a matter of urgency in a facilitated and participatory way which involves THQ, project management staff and uses donors, key govt. leaders and other NGOs as key informants to give context to the process.
   - This should also include a sustainability plan, which was anticipated in the DIP.
4. Don't bend to donor demands (e.g. one stop approach just because its USAID's agenda: explain your predicament to Salvation Army and get their support).

5. Find ways out of the project cycle dependency. Find ways of accessing more resources within your own org which are significant. Find ways of recovering costs and increasing efficiencies. More later.

6. Ask for help: SAWSO has resources for TA. Identify some specific activities or skills they need help in and ask SAWSO for TA or resources to hire TA to get them done (e.g.

1) some of the studies they might do, 2) rethinking their MIS system--see below, 3) helping with the design of a sustainability plan; 4) market analysis).

Sustainability

1. A critical aspect of all dev programs, and staff seem aware and committed to it.
2. Because of structure and underlying purpose of Salvation Army program, there is an inherent tension in the way dev projects have been conceived and implemented: not much concern about creating dependency as this not seen as inconsistent with the evangelical approach.
3. Also, Salvation Army intends to remain in communities for a long time so the pressure to create the conditions for local ownership and responsibility for programs, which drive other NGOs, is less pressing.
4. The give away approach, aside from creating dependencies, restricts the number of people the Salvation Army can and will ultimately reach, and can create negative feelings in communities where for one reason or another (in this case govt. requests) Salvation Army has to withdraw.
5. You know much of this. What is needed now is some hard thinking about the link between community ownership, empowerment and sustainability--both programmatic and financial.
6. I am disappointed that the Sustainability Plan has not taken shape, but understand this better based on some of the larger organizational issues. While financial sustainability is a challenge when it comes to health delivery, but think more could be done to look at alternative, creative approaches to cost recovery, impacts, efficiencies and revenue generation.

Recommendations:

1. Need a long term sustainability plan that is targeted and creative, but includes commitment from Salvation Army for the overall health of the project. Must be results-oriented in terms of costs and revenues and specific in terms of actions. Some ideas (all may not be feasible, just leave for your consideration):
    1. Leveraging their good standing, reputation.
    2. Continue to access medicines from govt. to max.
    3. Reopen idea of contracting w/govt. This is definitely happening.
    4. See if they can join the JSI scheme?
    5. Begin charging more for services and medicines: do this incrementally AND with constant dialogue w/communities re WHY: if communities want these services and understand the resource constraints of the Salvation Army, they may be more willing to pay. This is true partnership.
    6. At the same time, maintain quality of services as in the past.
    7. Look more closely at what resources they have and what the community has:
        - They have a model that seems to work: effective. Document it (More below).
        - Be scientific: Do a market analysis: what are people paying for services and medicines. What are they willing to pay? Peg your fees at this rate. A sliding scale which takes economic status is a good idea (like PKS).
        - Advertise the training center!

8. All of the communities we visited rely on a mixture of 3 sorts of service providers: 1) Salvation Army clinics who are linked to VHWs but also offer services more widely, 2) Govt. and private clinics and hospitals; and 3) community based healers and practitioners, and particularly what you call "quacks". Consider "quacks" as a potential resource for providing preventative info and services since they already to. Midwives trained to be more skilled and professional in their jobs: why not quacks?

Recommend that the plan be considered highest priority (before end of SAWSO grant) and that external TA be brought in to help both in getting the required information together and facilitating the process.

I want to talk more about the MIS system and the role of documentation in the context of sustainability in the next session.

Integration

1. Recognize this is just at the initial stages and intent is laudable.
2. Genuine integration has to happen at organizational, management, programmatic and implementation levels. This doesn't mean everyone needs to be able to do everything: that's asking too much. But it does mean that the program takes advantage of synergies as much as possible
   - e.g. health messages in literacy classes,
   - income generation projects looking at cost of additional births, investments in nutrition, education etc,
   - principles of income generation and marketing integrated into discussions of health service sustainability.
3. Need to know where program objectives and activities meet--at all levels from management to village worker.
3. Integration can also happen through strategic alliances. If resources are scarce, perhaps Salvation Army should focus on what it does best, and partner with other NGOs to deliver some of the other services?

A few other random points:

1. Training.

- Training is essential. Raises awareness, empowers people, continues profile of the project, acts as an incentive to continue working.
- Demand is higher than supply. This may always be the case.
- However, disappointed that they discontinued training when the center was being built. Could they not have done it somewhere else?
- In Indo where distances are farther, terrain rougher, the project is going to bring the training to the villages. Consider this possibility to reach more people.

2. **Gender**

1. Appreciate attention to this matter.

2. Not just donor issue: women's control over resources and decisionmaking has demonstrated impacts on health, family welfare and overall development.
3. NGOs need to model commitment. Good that they've hired two supervisors. An excellent first step. Consider target of all supervisors being women within 3 yr period: they are managing a women's health program.
4. Also consider hiring women into senior staff positions.
5. Not sure whether gender is part of training, but should be.

General presentation

1. Thank you all for hosting me, taking time to answer questions and organize meetings in communities.
2. Overall finding doing a very good job.
3. Meeting health objectives.
4. Quality=because of their commitment.
5. Volunteer programs hard to sustain. Doing this because of supervision, input and other incentives.
6. You have learned and achieved a lot, and are building on this learning. Want to focus in these comments on three aspects of this:
   Sustainability
   MIS system
   Documentation

Sustainability

1. Def: what is it? When there is still a need or demand for the service we are providing. In this case depends both on quality and availability.
2. Salvation Army started in Jessore and Bangladesh as a relief agency. So people came to know it for its donations. This is not partnership. This creates dependency. We have now learned that this is not good development.
3. You are still giving away a lot: services, information, medicines. In the short run the health education has raised awareness, changed behaviors, saved lives. It has also created a demand: people understand more why they need to practice FP, why it is important to get vaccinations, why they should bring their children to clinics when they have certain diseases. And this job is not over yet.
4. Now your challenge is to change your relationship w/comminutes from one where you are their protector--to wean them off the free breast milk, to teach them to grow their own food.
5. The CSG is an excellent first step. A good forum for starting the dialogue about community ownership. Need to share openly the Salvation Army situation: if you give away free services in one place, that uses up the limited resources you have that may be shared more widely. Like all other NGOs, eventually the Salvation Army may need to move to other communities that have not benefited from health services. This has to be incremental.
6. I have recommended to the management team that a long-term plan for sustainability be developed. This should include a hard look at what people want, how much they are paying, how much they are willing to pay. IT should also look at what it costs to deliver services, how you can make this more efficient.

MIS: Information is Power

1. You are overburdened with the amount of information you have to collect. Doing this very well: even govt. commented that Salvation Army is the only agency that always has its reports in on time.

2. But are you taking advantage of this incredible data source to inform management decision-making at every level, allocate resources strategically and plan? Not really. Asking only the WHAT question, not the WHY question. Not looking at change over time. Has the ability to compare intervention villages with non-intervention villages: this is powerful information.
3. Need to be able to understand trends in disease patterns to see whether package of interventions is still the most relevant. What tells you more: a table with a lot of numbers or a graph that shows change? (DRAW this).
4. Trends and the relative importance of specific diseases can be vital for an efficient program--decisions about how what training to provide workers, what focus for programs, what kinds of medicines etc. all bear of costs and impacts of program interventions.
5. Need to be able to isolate problem villages or clusters to provide special attention
6. And, perhaps MOST importantly: this data can enhance community education.

- Data we collected from small groups in PRA format indicates people's sense of key diseases is fairly consistent across intervention and non-intervention villages.
- If they are aware of trends they are better informed. If they can name the key diseases and understand causes and prevention, the impact of prevention and the cost of cure goes down.

Recommend:

1. Get some TA in how to integrate MIS system so it continues to feed govt and donors AND provides useful feedback for management.
2. Needs software which can do this.
3. Give responsibility for data analysis to CSG at the village level: Train VHW to work with a subcommittee to transform data into graphs or charts that help communities track changes and understand rates. Post these in schools, clinics, and community meeting places. Can give encouragement to programs.
4. Use this data for generating more funds: demonstrating impacts.

Documentation: Analyzing the *why*, understanding the *how*.

1. NGOs typically are not very good at this. We are too busy trying to achieve our aims to spend the time to reflect and write about them. But documentation is important because:

- it helps to articulate and test working hypotheses about the underlying reasoning for the problems we are addressing and the approaches we adopt;
- it gives us a chance to pull out lessons learned from what we are doing;
- it gives us a chance to share what we are learning more widely;
- it can be invaluable in generating funds from donors--if they can read about your program in a professionally presented document it sends a message that you are serious, organised, and analytical about your program.

2. Because of this last point, it can be esp. critical for the Salvation Army program in Jessore at this juncture. Need to demonstrate to donors (incl. govt) what the Salvation Army is doing that is different, better etc. than similar agencies?

3. Some possible Q's and issues that documentation might explore at this point:
    1. The cost/benefit of the VHW program: how much does it cost to field, supervise, train a VHW vis a vis the impact in terms of mortality, morbidity, awareness, behavior change. (Draw this)

Cost: VHW salary and benefits, training costs, supervision costs, supplies, a portion of project management
Benefit: changes in disease, mortality, awareness, behaviors, and presence of community volunteers, other programs (e.g. CSG)

- [The VHW in the Salvation Army program includes community volunteers who would probably not operate effectively or at all without the presence of a VHW. So you can include this as a benefit.
- You have some comparative data on disease rates in "survey" and non-survey areas: need some TA and perhaps additional data collection to make this systematic and analyze it.

    2. The role and impact of the Bari mother/TBA workers]

4. The DIP anticipated a comparative study of the doorstop and one stop FP program. This was not done.

- Why? Because another (research) agency was doing it.
- Yet, this is a critical issue, which you feel passionate about.
- You have govt. support for it.
- And you are already collecting most of the data you need for this type of study. An opportunity lost?

Recommendation:

1. Doorstep vs. one stop study be done by contracting to an outside agency under the close supervision of the project: get the technical input you need. An opportunity to learn and achieve obj. without expending the time you may not have at this point.
2. Ditto on the program impact (VHW study).
3. Encourage staff at all levels to be intimately involved in the analysis.
4. Publish and circulate widely in 2 languages.

Wish you all the best.

Debrief notes: Zambia

Zambia Debrief: July 19, 2000
Chickankata

Intro
1. Thank you for your hospitality and openness.
2. My first trip to Zambia and hope it is not my last.
3. Feedback today based on very short visit, and first impressions.
4. Presentation is as much comments as questions, and hoping we can get more of your thoughts during this session.

Context
1. You are working in an economic, environmental and health environment which has deteriorated since the beginning of the project 6 years ago. agriculture production and markets, livestock disease and access to water from many years of drought increased poverty at the same time government support for health and I assume other services has declined. At the same time that the capacity of the community to support itself economically has diminished, the demands it to support a growing number of dependents: orphans, people sick and dying of AIDS and related diseases, and the elderly has increased exponentially.
2. And on top of all of this you have been asked as an organization and a program to look at your own financial future.
3. In this situation many would throw in the towel and lose hope.
4. Yet I sense you have taken the challenges as an opportunity, and admire your tenacity in seeking practical and long-term solutions to the situation you are in. As a group you also seem curious and willing to take some risks and experiment. This is good. I commend you and challenge you to continue!

Major programmatic successes:
1. In your efforts to move beyond the walls of the hospital, and help communities to engage in ownership and prevention, you have managed to move the focus of your organizational culture from one that sees itself as primarily responsible to the mission and purpose of the Salvation Army, to one that is more attentive and attuned to the mission and purpose of the community you are serving (and in some senses this brings you full circle to the true purpose of the Salvation Army).
2. Moving the mission from curative to prevention, from charity to local responsibility, from centralized to community based is no easy task, and no doubt you will continue to face resistance and wrestle with some of the moral and logistical challenges within yourselves as individuals, in your program and in particular from a community which has come to depend on the Salvation Army to provide free and quality services for so many years. How far can communities really go in providing their own health care? What is a fair price to demand for services? How do you balance quality with sustainability? And what constitutes true partnership with communities?
3. In reaching out to the community, you have brought the community to you. Bram commented that when he lived here in the early 90s a gathering of headman inside the hospital to advise staff on strategy would have been difficult to imagine. And the

headmen we met talked like consumers, not passive beneficiaries. Traditional community structures were respected in the past, now they are part of the program. Now your challenge is to build on those structures to help transform health and economic status through them, bearing in mind that whatever we do in development necessarily provokes change. And asking the question: how?

4. You have successfully begun the process of creating a hospital without walls. Most of my comments today relate to that process.

5. Based on a preliminary comparison of KPC data from 95 to 2000, your successes in impacting on key health indicators is mixed, though I question some of the data and suggest you may wish to revisit it:

- Breastfeeding practice is still high but awareness of child nutrition has remained more or less the same.
- The number of women visiting a health facility at least once during pregnancy remained high at 95%.
- EPI and Vitamin A coverage has increased significantly.
- Rates of diarrhea in children remained more or less the same, as did health seeking behavior, though mothers appear to be more aware and proactive about their own responses.
- Levels of respiratory illness remained the same but mothers seem to be more aware of the urgency of treatment.
- The data on HIV awareness needs to be revisited as awareness of modes of transmission rose from only 47% to 55%--hard to believe given the immediacy of the epidemic here. Only 8% of people said they had cared for someone suffering from HIV AIDS in 95 and this did not change in 2000.
- The number of pit latrines in use doubled from 26% in 95 to 53% in 2000.

I would like to spend the rest of the time focusing on five key issues:

1) The MIS system
2) Sustainability issues as they relate to
3) Program structural and staffing issues
4) Community structures and in particular
   -Volunteers and
   -the CPT
   -the Salvation Army in community
5) Gender

The MIS System

1. Your efforts to develop an information system, which serves and links the variety of stakeholders in the hospital, outreach and community, are laudable.
2. This is no easy feat. But it is worth it.
3. The challenge before you now will be to get all of the stakeholders conversant enough with the system that it serves you not the other way around. That everyone can use it.

4. The MIS is an integral part of your sustainability plan because it can help you use resources efficiently by understanding trends in disease as well as isolating communities in need of special intervention.
5. I will recommend that SAWSO continue to provide whatever technical and technological support you need to continue to refine this system, and that your efforts be shared with other countries who are struggling with the same issues but not as far along in the development of appropriate systems.

Sustainability

The DIP for the second cycle of Matching Grant funding has the following to say about sustainability: "Program results will be sustained by:

- Maintaining and increasing relations w/other NGOs, GOZ, and other donors;
- Developing skills and capacity of community members to identify and resolve health probs;
- Training women trainers to work w/women and other family members in promoting good health;
- Remaining in the catchment area indefinitely"

I wonder how these look to you now?

1. When we talk about sustainability, we often focus on cutting costs, raising revenues while retaining quality. Your approach has included all of this, and underpinning it all has been the shift to community ownership.

Insurance

2. This is an exciting and well conceived approach to sustainability: one that has been tried in many places without a lot of success stories.
3. You have the relationship, structures, and credibility to pull it off.
4. Need to ensure vigilance in terms of transparency, quality and consistency esp in the early days so that misunderstandings do not arise.
5. Urge you to document lessons and results as you proceed.

Staffing structure

1. In looking at the staffing structure you have adopted, there appear to be many more separate, vertical components than one normally finds in this type of program.
2. You appear to have six discrete components to the health outreach program—Community Based Counseling, CHIN, Community Sanitation, Nutrition, Family Planning, and MCH, each of which has at least one staff at the facilitator level and counterpart volunteers in the community.
3. As a result of this, as I understand it, your mobile clinics include between 10-15 people. And you have a myriad of types of volunteers at the community level, each tasked with different but related activities.
4. The DIP anticipates a goal 1 CHW of per 500 population, 1 TBA per CHW, 1 CSW per village and 1 CPT per community. It anticipates training 30 new CHWs, 15 new

TBAs, 20 new Nutrition Demonstrator, 20 new Community Counselors, 15 new CSWs, 20 new Community Based Rehab Demonstrator, and 20 CPTs. In other words: an army of volunteers.

6. I wonder about the cost efficiency of this. Cannot some of the roles be consolidated? Cannot community health worker provide health, nutrition and hygiene information, as well basic health services?
7. The goal of 1 CHW: 500 population is a good one. It is also one that might be sustainable, as 500 population can possibly support one "volunteer" worker. In this scenario, the project could focus on upgrading the skills of this one worker, instead of spreading its scarce resources to many.
8. I recognize you are also dealing with the potential for drop outs and death, but suggest you might like to take another look at your staffing and volunteer structure to see if you can consolidate and streamline somewhat.

CPT

1. The CPT is the centerpiece of your program, representing your community ownership and empowerment goals.
2. As I understand it, the CPT is at once a focal point for community discussions on health and development, a point of contact for the project with the wider community, to dialogue with community, a representative body which can plan and lead community activities for health and development, a group of individuals who are committed to helping the needy and sick in the community, and potentially a social action group which can advocate and represent the community to government, donors etc.
3. The CPT overlaps with and parallels traditional and political structures. So in this way, you are in some ways, creating a new power structure in communities.
4. This all has huge implications for how the project supports and relates to the CPT. There are no prescriptions for this, and I appreciate the fact that you are wrestling with both of these. I would like to make a few comments on this.

Who participates on the CPT?

1. NGOs often refer to "the community" as if it is a homogenous whole. IT is not. The community includes people of different ages, gender, economic, health, educational status. Some people in the community have more access to information, skills, decision-making power, and resources than others.
2. When you give responsibility to "the community" to nominate members of the CPT you and they need to recognize this.
3. And if you want a truly representative body, then all members need to be at the table.
4. This is not easy. But it is important.
5. So, are you asking yourselves and communities: are people with less power, or less voice also represented? Are the concerns of people with AIDS, orphans, youth, women, the handicapped, the poorest of the poor heard in the CPT?
6. It is hard to get marginalized people into the discussion. But it is a risk not to.
7. I sense that you hesitate to be directive or proactive in this regard, but I urge you to initiate the dialogue in more depth with communities about who is speaking and

deciding on behalf of whom. Otherwise traditional structures which may continue to concentrate resources and power in the hands of those already in positions of power may reinforce existing inequities.

8. On a related subject, we did not ask or hear about the CPT's relationship with local Salvation Army churches or church members. IT seems like this could be a human resource worth mobilizing and perhaps you already are?

The size of the CPT

1. The CPT is very large to be an effective body for decision-making.
2. Your efforts at forming subcommittees is good.

Partnership with the CPT

1. The impetus for CPT formation seems to come largely from the project. This is ok, but there also seems to be an expectation that the project will resource the CPT to a greater extent than it is able or willing to.
2. I wonder if you have considered negotiating a kind of written contract with the CPT which would allow you to spell out what each side is obligated to—a kind of marriage contract, that can be renegotiated at future points in time?
3. You have adopted a counseling approach to partnership with the CPT in which you resist efforts to solve problems for the community, but rather seek to create a safe space for CPT members to do so. Part of this includes developing networks of CPTs to enable peer counseling. This is good.
4. But you are also stakeholders and should continue to explore the extent to which you should and actually DO get involved in discussions and disputes. I want to take this issue up again when I talk about gender.
5. Your initial training for CPTs touches on a host of very key skills areas, all necessary for building a CBO. It is clear from the reports of fledgling CPTs that much more is needed in each other areas—management of funds, conflict resolution, leadership training, and I encourage you to continue in your efforts to provide both structured training and hands on support. This should be a major focus of the next 3 years.

CPT as microenterprise

1. I also wanted to say something about the income generating activities of the CPT. While the CPTs activities certainly need to be resourced, I think it is a mistake to encourage a fledgling, volunteer community group to leap into a group-based enterprise as a first or even last step.
2. The potential for failure based on lack of expertise, mismanagement of resources, attrition, conflict is high and puts the whole CPT venture at risk.
3. This is not a small enterprise group: it is a community action group.
4. If funds are required to assist needy people, or launch community projects, it would be more advisable to provide credit, encourage savings and use this as an incentive for sharing with more needy.

Gender

1. A final point which I feel may be the most important and potentially the factor you can impact the most and with the greater results: gender.
2. The link between women's economic political and education status and the health of children and families has been well documented.
3. Here women are very vulnerable because they are in a subordinate position economically—cannot own or inherit property—and overall lack access to the political process.
4. This affects their ability to influence impt. Decisions related to their health and well-being.
5. The starkest example of this is their ability to negotiate safe sex: when we asked women in …….. village about condom use they said their husbands use it with their girlfriends but refuse to use it at home. When we asked whether they—the wives—could insist, they just laughed and shrugged. No.
6. But it is not a laughing matter. IT is life and death.

There are many things the project can do about this.

1. **Recruit more women health workers.**

- Women health workers can achieve status in communities because of the service they offer. They also provide a role model, and demonstrate that women can perform important community roles.
- Women in most cultures prefer to receive health information from other women.
- This might mean changing the venue and timing of training, but it is doable and worth it.

2.**Model gender equity**

- At the moment the face of the project at the community level is predominantly male.
- You need to practice what you preach.
- Put women in management positions.

3. **Require 50-50 representation on CPTs**

- This is part of being more pro-active as partners.

4. Include gender issues in all training

I encourage you to put this at the top of your agenda for the next 3 years!

Wish you all the best, and continuation of your good work.

Debrief with SAWSO

SAWSO Debrief
August 4, 2000

Intro

1. Thank SAWSO and esp. Faye and Bram for an excellent trip.
2. Commend you as an organization: have attracted incredibly dedicated people, long term commitment to communities, and impressive achievements, though rather humble about it.
3. You have been able to read my debrief notes for the countries, so will not go through them point by point today, but rather seek to synthesize and focus more on findings and recommendations about SAWSO in terms of partnership input and Matching Grant achievements.
4. Want to talk about your achievements both in terms of what you actually accomplished, but also to look back with you at what you could have done better (hindsight is 20-20 vision) which may inform the next 3 years in the new countries as well as the old countries that the Matching Grant will not cover, as I understand you will be working in all 3 at some level.
5. In doing this, and because of the nature of the funding, I would like us to ask the question about value added. Since your partners are local NGOs, what would have happened if the money had been granted directly to them? So what benefits did they derive from SAWSO?
6. I'm going to cover a lot of areas and I'm going to be far more blunt with you here than I will be in the report. The debrief notes will go into the appendices, but these notes will not unless you want them to.
7. As I said in the field—these are based on fresh eyes, impressions: may be off base, but its what I saw and some trends did emerge across countries.
8. Organize in topic areas and give you feedback and recommendations as we go through.
9. I will give you a copy of these talking points.

Overall

1. Because the Salvation Army has made a long-term commitment in all of the target communities, it was hard to separate the Matching Grant intervention from the overall program. This was good because it means that the project doesn't mark the beginning and end of an intervention that necessarily takes longer to have an impact. Also a challenge:
    a. SAWSO funding seen as covering operating costs;
    b. As a rule, the focus was primarily on the health impacts, and particularly in Indo and Bangla, much less on the longer term programmatic aspects of sustainability, documentation and advocacy;
    c. Only in Zambia did the Matching Grant seem to catalyze some sort of transformation in business as usual, so that staff could point to the Matching Grant as the source of the change;
    d. So, whereas the goal in both and particularly the second round was to raise the issue of sustainability, the country offices are still primarily

addressing sustainability in terms of where the next grant might come from.

2. Program design in all 3 places generally followed the govt. strategy for community health delivery.
    a. The Salvation Army is generally perceived (by itself and by govt) to be filling gaps in government service delivery.
    b. Salvation Army very well regarded in all 3 countries by govt.
    c. Do what govt does better (better resourced, managed, flexible, less bureaucratic);
    d. Does this limit the extent to which local Salvation Army offices are able, willing and inclined to innovate?
    e. Why are local offices not capitalizing on their good standing w/govt in terms of advocacy, documentation, modeling for govt. to consider replicability, contracting, scaling up etc.?

3. Matching Grant Program seems to be a series of vertical country programs: from DIP to implementation to reporting, not much horizontal sharing, synergy or communication across countries. Disappointing as opportunities for sharing and cross-fertilization of ideas abound.
    a. Strides on MIS and insurance schemes in Zambia might have inspired and assisted Indo and Bangla as they struggled with this;
    b. Strides on gender in Bangla could have modeled an approach for Zambia;
    c. Issues of integration w/in the program and dialogue with the Salvation Army structure which all countries are struggling with would have been an empowering topic for discussion, even if only via SAWSO reps, but possibly also via other medium (lack of internet in 2/3 sites makes this a challenge).

4. There are also some crosscutting issues about SAWSO as a partner and SAWSO as an advocate, which I'd like to take up at the end.

Some specific issues:

(a) Health Impacts

1. Good marks for this, esp. in Indonesia and Bangladesh.
2. Need to get the tables in order so we can show not only the immediate impacts, but behavior change as well.
3. Ask that they also get an estimate of the cost/person of the program. In Bangladesh and to a lesser extent Zambia this may be a challenge since the program may be part subsidizing a much larger catchment—need to give some proportional weight for this.
4. This kind of data can be powerful in convincing govt and donors to continue funding, esp. as a lot of the actual "costs" of this program are free in volunteer labor.

5. Insofar as we're asking local offices to do this kind of efficiency analysis, we need to do it at a programmatic level as well.
6. Also would like a table presenting training targets and achievements, perhaps in 3 year cycles.

Recommend:

1. Think about health impacts in *strategic* not just *output* terms: use information to leverage greater gains via
    1. documentation,
    2. advocacy (w/in Salvation Army, w/donors, w/host govts),
    3. modeling (x-countries),
    4. sharing lessons learned and
    5. Generating an internal and cross-country dialogue on quality and sustainability.

VI. MIS

1. This was an objective in all of the countries, but fell short of the mark in all countries.
2. 1996 Eval says of HIMS in Zambia: "HIMS almost operational". Still the case today. V. Interesting, important, and acknowledge the challenges in getting there, but this seems to be a centerpiece of the project which made too little progress.
3. 1996 Eval also says of Indo: "no evidence that records are being utilized as management tools, as aids top planning, monitoring, training, supervision, targeting either messages or population segments or to facilitate capacity building of staff at all levels". As far as I observed, nothing has changed.
4. The MIS in all 3 countries, but particularly Asia, continues to serve govt. requirements not the Salvation Army or the program objectives, and definitely not the community.
5. Definitely a sense of ownership around the KPC esp. in Bangla.
6. This is a good start. But its one-off.

VII. Recommend

1. MIS be a focus of the program in the next 3 years and be tied deliberately and directly to sustainability (efficiency, advocacy, management planning).
2. That SAWSO develop or identify appropriate technical materials, guidelines technical assistance or training modules to be shared with all offices to help them work this through.
3. That the Zambia experiment be shared with other Matching Grant offices as a prototype, which might be adapted (links hospital, with program, with community—this is relevant in all cases).
4. As above, the more you can model this in your planning and decision-making and use it in on-going dialogue w/country offices, the better. Not just milestone data like KPC but on-going MIS and budget data as well.

Volunteer Program

1. I have to admit that I came into this with a bias about volunteer programs. And this review changed my bias.
2. The fact that this project is supporting the number of volunteers that it is, is remarkable. And the extent to which they are having an impact is a major achievement of the project.
3. The volunteers are at once the foundation of the program, the Salvation Army's link to the community, and the most tenuous part of the program design because of the very fact that they are volunteers.
4. More needs to be understood about who becomes a volunteer, what motivates volunteers (this may be somewhat different in different cultures), and the costs and real impacts of volunteer cadres. Some Q's from the field:
    1. Will govt. take up the cost and supervision of volunteers if the Salvation Army pulls out?
    2. How many levels of supervision does a volunteer need? (Bangladesh, Zambia)
    3. How much training is optimal? (Bangladesh)
    4. How narrow or broad is the optimal level of responsibility of an individual type of volunteer? (Zambia)
    5. What is the community's role in remuneration?
    6. What can we learn about the leadership roles of volunteers, esp. vis a vis women in the community?

VIII. Recommendations

1. The Salvation Army is in a good position to explore all of these issues, which are broadly relevant to community health programs in developing countries: documentation, culling lessons learned.
2. At very least, lessons learned should be shared among participating countries and this issue should be on any cross-visit or centrally facilitated agenda AND within the Salvation Army international programming more broadly.

Village health committees

1. All of the countries attempted to form structures at the community level which could take ownership of health and development issues and serve as one tool for sustainability.
2. Bangladesh and Zambia demonstrated more abilities in this regard and are off to interesting starts.
3. Certainly staff are taking this aspect of the program very seriously and grappling with the real challenges of supporting village ownership.
4. A lot still needs to be understood about
    a. how these structures are formed,
    b. who participates,
    c. who they represent,
    d. how they function (or dysfunction),
    e. what kinds of external support they need to start and sustain themselves.
5. Zambia has made impressive strides in their efforts to empower and inform community org's through training and dialogue. Shame that Bangla and Indo have not benefited from their experience.

6. On another point: The 1996 Eval includes an important insight which I am concerned remains today: "…..conceptualizing the process as a long-term partnership of health workers and communities may be closer to the reality of community capacity building than is that of a near completely self-reliant community capable to address the myriad of health problems with al of their complexity."
7. You can be proud that your partners took the idea of community ownership and ran with it. But perhaps they've over stepped the mark?
8. SAWSO does not appear to have been very systematic in supporting this challenging aspect of the program, although there is a lot of literature about CBO's (including training modules and research) which could be accessed and shared. Need perspective, networking, ways to monitor and reflect on an on-going basis.

Recommendations

1. Some research be done into the literature and shared with country offices.
2. At the same time, some attempt at beginning a dialogue and sharing among participating CO's be launched.
3. Some mechanism for monitoring these committees be put in place so that more understanding can be gleaned in the next phase.

Sustainability

1. Although this was a target of the program in all countries and at the project level in both cycles of the matching grant, at the program level there is little to show at the end of 6 years in terms of lessons learned, guidelines, or even a consolidation of experimentation.
2. Lack of direction at SAWSO is reflected in the field, which appears to have been left to its own devices in this regard.
3. There is definitely a concern about sustainability, esp. cost recovery and all offices are starting to charge for services, seeking new project funding, looking at alternative income generating sources, and seeking to maintain income and in-kind income flows from government. This appears to be taking place in a rather haphazard manner, and understandably there is concern for the future of the program at current levels, particularly in Indonesia and Bangladesh.

Recommendations:

SAWSO needs to reflect on measures adopted so far, assess their effectiveness, share learning's across countries and be far more proactive on this issue.
Guidelines (Which need only be in the form of options and tools at this point) would be a huge help.
Technical assistance in planning and cost efficiency analysis should be made available to country offices in conjunction with quality assurance TA.
Country offices should be encouraged and supported to document pilots like insurance schemes in Indonesia and Zambia, hospital cross-subsidization in Indonesia, incremental charges for services in all countries etc.

Relations with government should be leveraged to the extent possible to ensure that integration and cost sharing is maintained and contracting arrangements put in place where possible.

Gender

1. This was not a big part of your objectives and was not specifically mentioned in my TOR's, but I consider it central to the achievement of health objectives and a fundamental part of any program; this is true for USAID and I trust for yourselves as well.
2. The program has not explicitly addressed this issue in planning or documentation on any level.
3. In my admittedly limited time in the field I only found two examples of where gender was addressed as an explicit issue in the implementation of the health program (there were more directed attempts in other parts of the program e.g. literacy and IGAs):
    1. in Bangladesh where two female VHWs had been promoted into the previously all-male ranks of supervisor and
    2. in Zambia where staff suggested to communities that village health committees (CPTs) have a gender balance. The results on this score were disappointing.
4. Gender has everything to do with health outcomes.

Recommendations:

1. Develop a gender policy with your partners
2. Offer/provide gender analysis training to partners
3. Be more explicit on gender aspects of targets and diligent about accountability
4. Keep talking about this

SAWSO as partner

1. The nature of your partnership with local NGOs is different than many other agencies because your partners are all part of the same superstructure as you are.
2. This is a strength in that you share the same values, work within the same organizational culture and, in theory at least, can rely to a certain extent on the parent body to cushion the partnership in times of need and dispute. It is also a potential strength in that lessons learned in one part of the global partnership have the possibility for adaptation and growth in another part.
3. I would like to hear more about how you perceive yourselves in the donor role. It seemed to me from what I observed that you see yourselves more in a reactive than a proactive modality: that although you may have jointly or maybe even independently set some of the broader objectives for the program, you did not see yourselves as responsible for nudging your partners towards addressing them (except perhaps in the case of the KPC).
    - Indo is the most striking example of this. I'm curious at how hands-off SAWSO was through two cycles of funding of what was obviously a floundering project. It seems that some of the issues could have been addressed through representation at the THQ, though conditionalities, and very directed TA.

1. What does capacity building mean in this regard?

2. Also, to what extent does SAWSO play an intermediary/advocacy role on behalf of the local partner, e.g. with THQ, government, donors etc. This is particularly relevant with local THQ's who manage the local dev projects so are, in theory, ultimately responsible for achieving objectives (?). As a donor agency, and project holder with the donor, this is relevant. Does SAWSO hold THQ accountable, and on the other hand to what extent does SAWSO advocate for the development staff. This was an issue in particular in Asia and to a lesser extent in Zambia, and seems to be somewhat fuzzy in terms of protocol.

Recommendations:

1. Use the DIP or other doc. As a kind of contractual agreement and make sure partners (THQ and implementers) know what it says.
2. Bring THQ to the table on a regular basis to review, renegotiate, revise.
3. Is this part of the dialogue about a philosophy of development (what about a philosophy of partnership)—Faye re. Col. Brekke et al.

SAWSO in the international arena

1. Things are changing/innovations occurring in the health arena in Salvation Army (from my small sample), but it appears that Ian Campbell and Co. are leading the charge in the eyes of the field.
2. Good to be allied with him, and reinforce his message.
3. Good to be seen as providing guidance, not just advocacy: how to, lessons learned, guidelines. Can SAWSO be more proactive in this regard: sustainability? Community volunteers? Insurance, cost recovery? MIS? Its all there: needs to be effectively networked and disseminated.

Summary:

1. You have a good program. You have the potential for a great program that can have more of an impact than on the some 150,000 people you are targeting. These comments have meant to look at the spread, replicability, scale up and impact on the Salvation Army culture, which you are well positioned for.
2. Recommended to Bram that the meeting of partners not be held here though of course everyone would like to come to the US but that you choose one of your sites to allow for sharing of lessons learned on site.

Appendix C

Persons Contacted

Bangladesh
Lt. Col. Bo Brekke, Regional Commander
Dr. Biswas, Project Medical Director
Mr. Shankar Nandi, Project Manager
Community Support Group members
Local Village Health workers and Midwives
Government of Bangladesh Family Planning and District Health Officers
Dr. Rita Sen, PRIP Trust
Moslehuddin Ahmed, MPH, Project Management Specialist, USAID

Indonesia
Major Nopo, Palu In-Charge
Jonathan Topo, PHC Coordinator
Maximillian Ner, Environmental an d Clean Water Supervisor
Harun Gonta, Agriculturalist
Dr. Ellen H. Mentang, Hospital Medical Director
Dr. Herman Wilbowo, Sulawesi Health Dept.

Zambia
Commander Tadious Shipe, Territorial Commander for Zambia and Malawi
Lt. Col. John Hassard, Chief Secretary
Mr. Elvis Simamvwa, Chickankata Health Services Director
Ms. Ruth Muzumara, Nursing Care Manager
Mr. McDonald Chaava, Outreach Coordinator
Lt. Col. Damon Rader, Mission Chaplain
Chief Mweemba, Tonga Chief for the Chickankata area
Mrs. Kalichi, retired TB and HBC nurse
Mr. Romeo Singogo, Health Promotion Coordinator (Clinical Officer)
Mr. C. Mangombe, Community Based Rehabilitation Coordinator (Clinical Office)
Mr. Cramwell Mweeba, Community Counselor
Mr. Patrick Hachintu, Chin Orphan Program
Ms. C. Kamwale, Nutrition
Mr. J. Chisabi, Environmental Health

Appendix D

Evaluation Team Itinerary

June 24 Depart U.S.: travel via Singapore, Ujang Pandang
June 27 Arrive Palu
Meetings with senior staff
June 28
Met with Puskas Mas (Clinic) staff, Kulawi village
Met with Kadars, Gimpu village
June 29
Met with Kadars, clinic staff in Watu bula
Met with Kadars and mothers in Maranatha village
Met with village leaders, village health committee, kadars and mothers in Lampelero village
Met with Dr. Helen, Director of Salvation Army Hospital, Palu
June 30
Salvation Army staff discussions: individual
Met with Government health officials, Palu
Draft findings and recommendations
July 1
Debrief with senior staff

July 2
Depart
July 3-6
Personal time
July 7
Travel to Dhaka
July 8
Rest day
Dinner with THQ
July 9
Travel to Jessore
Meeting with Salvation Army core team: overview and planning
July 10
Met with clinic staff: Jessore
Met with senior staff
Met with Sujolpur Community Support Group, clinic staff, health workers, mothers
Met with Dakatia Community Support Group, health volunteers, mothers
July 11
Attended Population Day launch
Met with Ramnagar Community Support Group, health volunteers
July
Met with Birampur mothers (Salvation Army phased out 10 years ago)
Met with Chief Surgeon, Jessore
Met with chief of District FP program
Met with Program Manager and Medical Director
July 12
Debrief with staff

Travel to Dhaka

July 13-14
Travel to Zambia
July 15
Rest day
July 16
Travel to Chickankata
July 17
Met with senior staff and planning field visits
July 18
Met with technical staff
Visit to 2 Salvation Army villages: …and Simweene Village: met with community health workers, CPT members, village leaders, mothers
July 19
Met with CPT Training team
Met with Hospital Director
Met with Council of Headmen
Met with Chief of Council of Headmen
Visit to Chickambolla Rural Health Center
July 20
Debrief with staff
Met with District Health Officer
Travel to Lusaka
July 21
Debrief with THQ
Debrief with USAID (by phone)
Depart for US
July 22
Arrive US

APPENDIX E

Comments On Matching Grant Evaluation Report

By

SAWSO

COMMENTS ON MATCHING GRANT EVALUATION REPORT

SALVATION ARMY WORLD SERVICE OFFICE
October, 2000

In August, 2000, USAID/PVC carried out an evaluation of a USAID-funded Salvation Army World Service Office (SAWSO) Matching Grant implemented in Bangladesh, Ghana, Indonesia, and Zambia. The consultant, Ms. Laurie Zivetz, traveled to three of the four countries (Ghana was excluded) along with the SAWSO Program Consultant responsible for the particular country. This document presents SAWSO's comments on and clarifications to the consultant's draft report. It is presented in two sections: *Section I* provides a response to some of the general organizational issues raised by the evaluator in regards to management of the grant and to SAWSO's role in relation to its local Salvation Army partners. *Section II* provides comments on specific text and passages from the consultant's report.

Section I – ORGANIZATIONAL ISSUES: SAWSO, THE SALVATION ARMY

SAWSO's Strategic and Technical Role in The Salvation Army

Two main themes that emerged from the evaluator's observations about SAWSO related to a "vertical approach to program support and implementation" and SAWSO's "relative weakness in assertively promoting change in its partners."

Over the past three months SAWSO has begun a systematic re-evaluation of leadership and management issues, organizational systems and processes, and its ways of working together as a team. As part of this process, the organizational vision and mission were re-visited and updated (see below), and there has been a restructuring of management responsibilities. Processes are being established to formalize project identification, development, and funding; contractual relationships with Territories; and monitoring and reporting. Over the next several months this strategic planning and reflection exercise will continue with in-depth discussions on SAWSO focus areas, strategies, organizational systems and procedures, role in relation to local Salvation Army Territories, and ways of working more effectively with the Territories. New procedures have been established in the office to facilitate a team approach and systematic sharing and dissemination of technical information, innovations, and strategies, both within and outside of SAWSO.

With an increased clarity regarding its purpose, SAWSO will be able to take a more pro-active leadership role in raising and discussing specific project-related and broader development related concerns and issues with THQs and governments.

In regards specifically to MG III, a Program Consultant has been assigned to take responsibility for overall leadership and management of the grant. A DIP for Headquarters is being developed that will include a coordinated technical assistance plan to address issues common across MG countries such as cost analysis and a qualitative Community Assessment. Weekly meetings on MG implementation will be held at which technical strategies and approaches will be developed and shared, along with regular updating and discussion of day-to-day implementation issues. Plans for travel and technical assistance will be reviewed and approved by the MG team

(consisting of the three Program Consultants with MG responsibilities and a fourth Program Consultant with expertise in micro-credit) to ensure sharing of lessons learned and that key elements of the grant are being implemented.

We believe that these specific changes in management of the grant, along with the broader reflection process ongoing at SAWSO, will result in more cohesive and coordinated project implementation and management, and will address many of the issues raised in the evaluation in regards to SAWSO Headquarters, including Recommendations number 1, 2, 4, 5 and 6.

SALVATION ARMY WORLD SERVICE OFFICE

Vision:
Create a world where people live in safe and sustainable communities in which differences are celebrated, basic needs are met, and all enjoy opportunities to learn, work, and worship freely.

Mission:
To support and strengthen the Salvation Army's efforts to work hand in hand with communities to improve the health, economic, and spiritual conditions of the poor throughout the world.

Section II – COMMENTS ON DRAFT EVALUATION REPORT

The following section provides SAWSO comments on specific statements made by the evaluator in the text of the draft report. The evaluator's comment is provided and SAWSO's comment follows in bold.

Executive Summary

Evaluator: Despite its emphasis on sustainability in this three-year cycle, the program lacked an integrated plan for sustainability and capacity building.
Nonetheless, efforts to address sustainability were by and large random, and remain uninformed by a broader Salvation Army or SAWSO framework, a coherent plan, targeted technical assistance, or reference to the literature.

Efforts to address sustainability were not random. At the beginning of the grant period project staff were introduced to the concept of sustainability and began to consider how outreach activities could be sustained after termination of donor funding. Training on cost analysis was conducted for project staff in Bangladesh and Indonesia. Sustainability workshops were conducted in Ghana, and were followed up by a workshop on how to conduct a feasibility study. This was in response to the interest expressed by project staff in establishing income generating activities. All of the countries planned and implemented various strategies to generate revenue to support their outreach services. During 1999, SAWSO developed a draft framework for sustainability, the result of many months of discussion and reflection on the concept. This framework is evolving and will be further developed and refined during the current grant.

Gender

Evaluator: Although not an explicit objective of the MG, gender was not addressed in the design or implementation of the program or country projects. More needs to be done to redress the staff profile, volunteer and supervisor recruitment and design limitations which may be inhibiting optimal achievement of health program objectives based on lack of attention to gender

The importance of gender issues is a valid observation; however, since it was not an explicit objective of the MG, gender issues should not be used as a measure of the success or failure of the grant. SAWSO recognizes that gender roles, relationships, and responsibilities must be understood in order to design and implement effective activities. The Program Consultant hired in 1999 has expertise in gender; during MG III, SAWSO will seek to build awareness of gender issues by mainstreaming gender considerations into major project activities. For example, the qualitative community assessment will include questions exploring the impact of gender roles and responsibilities on utilization of outreach services, health-seeking behavior, and decision-making about household expenditures.

Evaluator: Mechanisms for sharing information and learning between THQs (and at times between projects and THQs when they are geographically distant) are similarly undeveloped.

While formal mechanisms for information sharing may not be well-developed, there is nevertheless a great deal of information sharing and learning that occurs within The Salvation Army. Many of the outreach staff from the Chikankata program in Zambia, for example, have shared their experience concerning Care and Prevention Teams (CPTs) with programs throughout Zambia as well as with programs in Uganda, Tanzania, Zimbabwe, Kenya, and South Africa. Lessons learned have helped The Salvation Army in Malawi develop a program that is part of the PVO/NGO Networks for Health Project. SAWSO has established an outreach program with Mountain View Hospital in South Africa that is based on the lessons learned in Zambia and through the Matching Grant.

II. b. Country Trends and Salvation Army history

Indonesia

Evaluator: Government directives, coupled by reductions in SA staff and resources, have led to reductions in the number of communities reached by the SA over the last 6 years.

The reduction in the number of communities reached by the SA over the last six years was not the result of government directives. Rather, reductions in the number of communities reached by the SA, or downsizing, were deliberately made as a way to make the health program more sustainable. During year one of the grant SA project staff identified communities in which SA services overlapped with government services. These communities were notified by letter and through on site discussions that the SA would no longer be providing services. Government officials and government clinics were also

notified. Over the first two years of the grant the SA gradually withdrew from 24 communities, but made periodic visits to see whether the government clinics planned to take up the responsibility for services, including support for posyandus. With one exception, communities and the government clinics seemed to be working out ways to sustain the program.

The evaluator suggested that the SA might address financial sustainability by appealing to the government to help the SA because they were "filling a gap" in the health sector. Although this option will be pursued, withdrawing from communities in which the government had the infrastructure in place but had allowed the SA to carry the burden of providing services for many years seemed a very practical approach to sustainability.

III. Health Impacts

Indonesia

Evaluator: Disappointing results in immunization coverage, attributed to government inefficiencies, may have been addressed with data from an informative MIS system and a more proactive project management team liaising with government, addressing gaps, and reinforcing follow up.

The Government of Indonesia severely reduced the amount of vaccines it was providing to NGOs in general, including The Salvation Army. This necessitated The SA eliminating its provision of vaccination through outreach services, and offering them only through its health facilities. Although the government promoted mass campaigns for immunization and Vitamin A coverage, their coverage was very poor, especially in the remote areas where the SA had a presence.

Evaluator: Access to immunization, as measured by DPT1, reached targets, but immunization dropped off significantly following this. Although SAWSO attributes this to deficits in availability of vaccines from government, this merits more investigation. Certainly a case could be made for increased advocacy to government, if this is indeed the case. The role of village health workers in immunization is relevant in this regard: did they alert rural clinics or SA staff of these deficits?

SAWSO's information came from the project staff during TA visits in which data regarding immunizations was reviewed. A case can certainly be made for advocacy to the government and will be done. How effective this will be given the current economic conditions in Indonesia is questionable.

Bangladesh

Evaluator. Bari mothers, tasked with distributing ORS packets, may be overemphasizing this popular treatment at the expense of other, less externally-dependent treatments;

The use of home available fluids and sugar salt solution (SSS) to prevent dehydration from diarrhea is an integral component of Bari mother health messages and advice. For

treatment of dehydration due to diarrhea packets of ORS are appropriate. Formerly, mothers went to the clinics when their children had diarrhea instead of to the Bari mothers. By providing packets and advice at community level valuable time is saved and the dehydration is managed more effectively.

IV. a. Community Health Volunteers

Evaluator: In all countries, training of Traditional Birth Attendants (TBAs) is part of SA and government schemes.

TBA training in Indonesia has been abandoned by the Government in favor of training of Certified Midwives (nurses with special training). The SA continues to conduct refresher training for TBAs already trained since the placement of Certified midwives in rural areas has taken a long time.

Training

Evaluator: The Bangladesh program suspended training for an entire year while its training center (a centerpiece of its income earning sustainability strategy) was being constructed. To recover lost ground, 2000 is being billed as a training year.

Although some formal training was discontinued during this time, refresher training continued for all project implementers (See training report).

Evaluator: SAWSO appears to have had only minimal input into training curricula or training methodologies, whether because government curricula were available or because they were not asked

The Salvation Army/Bangladesh has a very competent health staff with years of training experience in the Bangladeshi setting. This staff designed their own curriculum based on UNICEF health messages, embellishing on and improving the UNICEF materials by the addition of cartoons and drawings appropriate to non-literate mothers. They recorded their own commentary to accompany slide presentations on health issues, making them comprehensible to community mothers. They also used their considerable dramatic talents to present health messages by plays and musical accompaniment. SAWSO's input into the training curricula and methodologies included review of curricula, providing access to training materials available outside the country (Especially from the TALC center in London) and recognizing and encouraging staff to use their own ideas and considerable talents. SAWSO reviewed training content and methodology and the Program Consultant was present during several training sessions. SAWSO considers this an example of South/North learning as well as North/South skills sharing.

In Indonesia, the SAWSO Program Consultant visited posyandus to observe training and/or nutrition counseling during TA visits. She observed the training sessions for technical quality and participatory approaches. Afterwards she discussed her observations with health staff and initiated changes as necessary.

In Zambia the SAWSO Program Consultant reviewed the curricula for training community volunteers through a workshop and technical assistance with the staff. The curricula for most of the cadres of volunteers is documented, but was not asked for by the consultant during her visit to Zambia.

Evaluator: UNICEF's *Facts for Life* curriculum was provided to the SA in Indonesia, but appears not to have been adopted.

SAWSO provided various training materials including Facts for Life books when they became available in the Indonesian language, posters, and SSS spoons. Facts for life books were distributed to each posyandu and were seen to be in use as recently as at the last technical visit in March . The evaluator's conclusions were based on visits to a limited number of communities.

Supervision

Evaluator: In Indonesia, the number of supervisors has all but evaporated, with staff claiming they have had problems in recruitment.

Recruitment of supervisors has been a recurrent problem. SA THQ policies with regard to moving officers for reasons not related to project needs, particularly the removal of health professionals as project managers, has been particularly damaging to both the quantity and quality of supervision. Fear of travelling during times of political upheaval has also affected supervision.

Sustainability

b. Community Health and Development Committees

Evaluator: In Indonesia, village health committees had been established under a government initiative with limited results. Project efforts to revive these committees or create new ones did not succeed. It appears that currently in Indonesia health concerns have been incorporated into traditional village-based leadership structures by including of kaders who have shown leadership qualities into these structures.

When communities resisted the establishment of health committees in the original MG, it was decided to use the existing community leadership structures instead. Kader leaders are included in the traditional structure, so reverting to this structure rather than continuing to insist on a separate health committee was a rational and appropriate choice. Because of the confidence inspired by participation in the MG, Kader leaders have felt empowered to speak up at village leadership meetings and feel that they have had an impact on decisions made there (this latter by self-reporting). This was a deliberate choice by project staff, based on their experiences. It does not represent failure but rather a local adaptation appropriate for the context.

Evaluator: The establishment of community committees raises another, longer term issue in terms of the extent to which these committees—created with a development

agenda—compete, compliment or interface with community-level Salvation Army corps which have an evangelical focus.

Historically there has been tension between the evangelical mission of The SA and the commitment to development. The Integrated Mission Approach to Salvation Army activities, pioneered through its HIV /AIDS work and now officially incorporated as a global strategy, has helped to ease this tension. The international leadership of the SA is committed to this approach, and THQs and project staff in every country are gradually acquiring an understanding of and commitment to this integrated approach. In a sense this is a rediscovering of the original mission on which The Salvation Army was founded over 100 years ago.

Evaluator: Ironically, the Army's profile in the communities has been as much an enabling factor as a stumbling block, as communities are confused, and sometimes resentful that they are being asked to assume the burden of responsibility for services and decisions which for so long have been borne by the Army."

This is an issue that The Salvation Army is addressing around the world, as it transitions from its traditional "welfare" or "charity" approach to an approach focused on community participation and ownership. There is a shared recognition among the SA Development Officers around the world that the charity approach is not sustainable, and that building local capacity is the key to achieving and sustaining long-term improvements in quality of life of individuals and communities.

SAWSO strives to play a role in facilitating this transition by sharing experiences in which a change in approach has been achieved with demonstrated success. For example, in order to explain the need to introduce fees-for-service, a Salvation Army health centre administrator in Haiti shared expenditure and revenue information with her staff, and the staff then shared this information with its clients for several months. As a result of this transparent approach, the community today pays for services without question or complaint. SAWSO is developing a case study to document this approach and share it throughout the SA, and specifically in MG countries.

SAWSO is also working on a Community Development training curriculum to be introduced into The Salvation Army Officer Training Colleges; the curriculum will address basic principles of development such as inclusion, ownership, participation, and community capacity building.

Evaluator: A closer comparison of the composition, costs, and impacts of this approach [mobile clinics] vs. community-based volunteers and fixed clinics – all part of the constellation of services in both countries – would inform future sustainability planning. **A cost analysis of outreach services will be conducted in the first 6 months of MG III. In addition, qualitative research will be conducted in the communities to determine use of outreach services, perception of the services, and whether/how the services are valued within the community.**

V. Information and Documentation

a. Management Information Systems: objectives and achievements

Evaluator Sharing of experience and expertise across countries—particularly from Zambia where the system is the most evolved, could have energized and informed all four countries participating in the MG, and most likely led to greater progress on all counts. Capacity building in Management Information Systems design has fallen short of expectations.

In Bangladesh the existing MIS system was revised to include both government requirements and project requirements. Subsequent assessment of the MIS system by SAWSO consultants and project staff resulted in some modifications. As noted by the evaluator, use of data is an issue in Bangladesh, but not the system itself.

In Zambia, while progress has been slower than anticipated on establishment of the HIMS, system, there is strong commitment to its use and development and steady progress continue.

VI. Sustainability

Evaluator: Given the absence of a comprehensive sustainability strategy for the MG, it is disappointing but not surprising that none of the country offices undertook to develop their own sustainability plan

Both Bangladesh and Indonesia engaged in sustainability planning and implementation during this grant. Strategies implemented, such as down-sizing (Indonesia), Training Center (Bangladesh), and various Income Generating Activities were tried. In Ghana, for example, income generating activities attached to clinics have included animal husbandry (goats, rabbits, chickens, snails), sale of oil palm seedlings, production and sale of bread, palm oil, eggs, mushrooms, and Weanimix. Chairs and canopies have been purchased and hired out for community functions, and coffins and wreaths have been made and sold. Monies as profits after the capital costs have been taken have been deposited in high interest accounts or treasury bills. The evaluation of these strategies and the incorporation of new ones will be an important part of the sustainability plans adopted in the new grant.

VI. a. Cost Recovery

Evaluator: Bangladesh: The Jessore health service, the largest SA project in the country, set itself a 20% cost recovery target over the life of the MG. In 1999 it reached13%. Nonetheless, with an operating cost of $250,000/year,[29] the program is along way from self-sufficiency.

The operation cost listed is for all SA health services in the Jessore area, of which the MG project component is a small part. The cost of operating the outreach program is less than $40,000 USD.

[29] This includes operating costs for the clinic, and community health and development activities.

Evaluator: Two other creative attempts to generate funds at the project and community levels bear comment:
1. In Bangladesh, MG funds were used to expand the Training center in the SA offices in Jessore. A good idea in principle, justified also by the fact that it is the only training center in the area where the proximity to a clinic offers the opportunity for experiential learning. But it is by no means the only training center in Jessore, and will require staff time not only in advertising, but also in managing and maintaining it. The jury is still out as to whether this was a sound idea, given current staff resources and the assumptions made about local demand.
Assumptions about local demand were based on a preliminary market survey, including price comparisons with the few other training centers in the area, and requests from other agencies for trainers and training sites with access to clinics. The training center has already been booked months ahead. An assessment of operational costs and real profits will be ongoing and data is collected now for use in future assessments.

Insurance schemes

Evaluator: Although the DIP and annual reports suggest that an insurance pilot was planned and implemented briefly in Indonesia, the evaluation found no evidence of it in any of the communities visited, and staff seemed unaware of this activity.
Insurance schemes were set up during the first grant period, based on an old government-promoted idea, and systems for monitoring them were put in place. Apparently they were not used and eventually the structure dissolved.

Evaluator: The evaluation discovered a mini-insurance scheme which, although originally a government program, appeared to have gained support and momentum from the project. Volunteers in current and non-current communities are collecting fees from mothers participating in the *posyandu* to cover costs associated with the monthly baby-weighing sessions which also include feeding for malnourished children, immunizations and basic medicines. According to the volunteers interviewed in two such villages, all mothers participated in the scheme. Fees range from Rp 250-500/month (US$0.03-0.06). Mothers who were unable to pay, were still allowed to participate and defer payment until the next month.
Although this system obviously works well, it is not an insurance scheme but rather a fee-for-service system that was put in place at the beginning of the project. It has the potential to sustain posyandu activities in future and is one of the successes of the project.

VII. Structural issues

a. The hospital, the clinic, and the community: staffing and structures

Evaluator The Indonesia program is by far the most vulnerable….key health personnel have been withdrawn from the program over the last two years, leaving it currently with only one junior nurse; other senior staff have limited public health expertise.

Two kinds of key health personnel have been withdrawn, the Nurse/Project manager and the senior nurse. The SA policy about transfer of officer personnel without regard to

project activities is an issue of concern within the SA. Future projects will include commitment by the SA Headquarters to leave key personnel in place for the life of the project. This has worked well in other SA health projects such as the Kenya Child Survival project.

Evaluator: The skeleton team, with neither a vision for itself nor established structural links to the financial and institutional core of the SA health services in Palu, and with no other sources of external funding, may retreat back into the hospital from whence they were seconded. The project, having run its course, may too. This situation is ironic, given the interest and vision of the Palu hospital Director in making the Palu hospital a "hospital without walls". Without strong organizational links between the hospital, rural clinics and the community outreach program, opportunities for this to happen have been missed.

The links between the hospital, rural clinic, and the community outreach program, though informal, are strong, and there is a commitment by all these players to continue health services at all levels, including outreach. The hospital will take on support of the outreach activities.

VII. d. Relations with NGOs

Evaluator: Although as an organization, the SA identifies with other Christian agencies, it does not appear to seek alliances with any of these organizations regionally or globally.

As an agency, however, the SA does not appear to actively seek linkages with other NGOs for technical, information sharing or advocacy purposes. It is not clear whether this is intentional or by default.

Either way, it is likely to be as much the result of its evangelical and apolitical mission, as the SA hierarchy itself which provides a built in global network which may preclude a felt need to actively network with other NGOs.

While the degree of networking and partnering does vary among different Territories in the Army, SAWSO feels it is inaccurate to characterize the agency according to this generalization based on the limited experience of the consultant with visits to only three SA Territories. The Salvation Army/Zambia actively seeks out partnerships. It works with UNICEF, WHO, John Snow International (JSI), CARE, Christian Medical Association of Zambia (CMAZ), and World Vision, as well as District, Provisional, and National government. The Hospital Administrator at Chikankata is in constant discussions with personnel at the National office of the MOH in regards to health policy and health reforms.

In Ghana, (not included in the evaluation), the Matching Grant project staff network and collaborate with the following: Christian Health Association of Ghana (CHAG), Christian Council of Churches, UNAIDS, UNICEF, Legon University, Korle-Bu Teaching Hospital, MOH at both District and National levels, Church leaders, Catholic Secretariat, British Development Office, Planned Parenthood Association of Ghana, National AIDS Programme, and various educational institutions.

In all four countries, the SA health programs have connections to the Christian Health Associations and to the Ministries of Health.

SAWSO actively builds partnerships with external organizations, both independently of and in collaboration with The Salvation Army Territories. SAWSO works with Counterpart, International, in a consortium with other PVOs to provide training and technical assistance to help the NGO sector in Ukraine and Belarus. The Salvation Army collaborates with World Vision in South Africa, and the SA and SAWSO wrote a proposal (unfunded) with World Vision and URC for a grant in Zambia. SAWSO's recent Child Survival proposal for South Africa includes a number of PVOs with whom agreements were established regarding collaboration and provision of technical assistance in the project (the proposal was not funded; SAWSO plans to resubmit it in 2001). Many other examples could be provided of collaboration, with UNICEF, Johns Hopkins University/Population Communication Services, SEEP Network, Pact, local governments, Ministries, etc.

VIII. SAWSO

a. Technical and capacity building support to country offices

Evaluator: SAWSO maintains a small office of ten staff, who divide the country backstopping and technical assistance responsibility among them.

Four program staff have backstopping and technical assistance responsibility for all of SAWSO's development projects; three of these Program Staff are specifically involved in the MG.

Evaluator: And yet, looking back, in light of the task SAWSO set itself, achievements appear to have occurred more by serendipity and less by design, and opportunities, particularly for sharing and synergies, have been missed. Neither integration nor sustainability—key foci of the overseas program—were modeled nor given concerted consideration at SAWSO.
A key objective of the project—sustainability—remains an intangible, in part because until very recently staff did not sit together on a regular basis to think through a framework. Neither did SAWSO model the active use of monitoring data to discuss programmatic issues with field offices.

Sustainability was introduced and followed-up on during TA visits; workshops and discussion groups facilitated by SAWSO as well as Sustainability training for in-country staff were held in Indonesia, Bangladesh, and Ghana. SAWSO staff discussions about sustainability were held during the grant, and several attempts were made to articulate a sustainability framework. The Sustainability Planning and Analysis (SPA) process was the result of careful thought and discussion on the topic of sustainability. It continues to evolve, and will be developed further in the current grant.

Technical Assistance

Evaluator: SAWSO direct, technical assistance, training, or government or NGO networking appears limited. SAWSO could have done more to act as a screen and conduit for information and to help identify issues and local consultants for technical assistance and training.

No reports, articles, or the provision of SAWSO-delivered training were mentioned.

For any international organization that works in partnership with local NGOs or local field offices, a balance must be maintained between providing leadership and technical support to guide local efforts and priorities, and allowing the field to set its own agenda and plans. Because SAWSO works at the invitation of SA Territories, maintaining this balance is essential to establishing and maintaining effective working relationships. Over the past several years, the balance has perhaps gone too far towards allowing the field to set its own agenda and responding to direct requests for assistance, and away from the role of providing leadership and guidance. This is something that SAWSO has recognized and is seeking to address in an ongoing strategic planning process. We are, however, committed to working in a participatory way with communities and do not plan to dictate their direction as that is not sound development practice.

While SAWSO recognizes and acknowledges that it could play a more active leadership role in introducing technical innovation, it is felt that the evaluator's statements do not accurately characterize SAWSO's inputs in the Matching Grant:

- **Technical assistance visits to Zambia included review of curricula for the training of the various cadre of volunteers, working with project team and consultants on the development and revision of HIMS forms, working with outreach team to document community counseling process, workshop on the importance of HIMS system and development of a plan for implementing HIMS, introduction to cost analysis, training on conducting KPC survey.**
- **In Indonesia and Bangladesh TA included curriculum assessment, assessment of the technical quality of implementation points, introduction to sustainability and introduction to cost analysis via workshops and discussion groups; follow-up and review of sustainability strategies were a part of every TA visit. Information about improved approaches to health issues, such as Malaria, Clean Water, Breastfeeding and ARI as well as new disease issues such as arsenic contamination were collected, reviewed, and carried to the field on every TA visit. Routine help with reporting and contacts with other USAID and government entities were also part of every TA visit.**
- **In Ghana, the Program Consultant introduced project and clinic staff to the Community Health Education and Skills Toolkit, a resource for participatory health education on maternal and child health topics developed by the MOH/Ghana and Johns Hopkins University/Population Communication Services. Linkages were established with the MOH/Health Education Unit to provide this kit free-of-charge to all SA clinics, and a joint training was conducted for project staff with the MOH/HEU on using the kit and participatory approaches to health education**.